University of Alberta

STRUGGLING TO ACHIEVE PROFESSIONAL RECOGNITION: A CASE STUDY OF NURSING IN CHILE

by

Eugenia Urra

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CHAPTER 1:

SITUATING NURSING IN THE CHILEAN CONTEXT

Nursing and nurses have been affected by social, economic, and political changes that have led to transformations of Latin American societies over the past two decades. Nurses in Chile's mixed public-private health care system have felt the impact of health reform on two fronts: on one hand, there is more work available, especially in the private sector; and, on the other hand, they have less control over their profession activities through what has often been the demise of authority in professional organizations. As well as being a predominantly female occupation, nursing has traditionally been limited and devalued by the male-dominated culture in the country. Thus, the development of professional nursing practice and a professional identity is difficult.

Achievement of professional status has been made even more difficult by global influences. During the 1980s the role of the state in countries in Latin America was limited with regard to the development and expansion of social programs such as health and education by the terms of the World Bank's Structural Adjustment Programs (SAPs). To receive World Bank funding, its guidelines had to be accepted. One of the results has been the reorganization of the health care delivery system. The responsibilities of the state in public health services have been constricted, whereas the increased development of private sector health facilities and services has been supported, which has led to a variable mix of private and public health care services in Latin America. What this means in practice is a shift "from a charitable to a financial focus" (Manthey, 2000, p. 3). Not surprisingly, concepts such as cost effectiveness, efficiency, and free choice engendered via the "free market" dominate health care discourse. This shift in ideology from a service to a profit orientation affects the parameters used to assess health care services, including

nursing care and staffing needs. As well, the public and private sectors are in competition for employment of qualified health professionals.

In this context Chile's introduction in the 1980s of a public-private mix in the financing and delivery of health services is typical of the region. Being economically and politically stable, with good health indicators such as sociodemographics and epidemiological rates (Pan American Health Organization [PAHO], 2002), Chile is a fertile context in which to understand and learn about the strengths and weaknesses of private and public sector investment in the health of a nation. The combination of public and private sector involvement in Chile seems, at first glance, to produce adequate health outcomes (WHO, 2002). There is, however, a disturbing increase in the inequalities between the rich and the poor in terms of the availability and quality of health services. Moreover, a comparison between the two health care systems does not demonstrate that the private health sector is more efficient than the public (Azevedo, 1998).

Professional nurses—those nurses who have graduated from a nursing program in a Chilean university—have played a vital role in the maintenance of adequate health indicators in Chile. They have, however, been an occupational group with a limited public image and little influence in policy making. Nursing has traditionally been a career for women, who have been less visible than men in society, especially in the public arena. Since the 1980s professional nurses have also seen some changes in their distribution in the new health care delivery system. With educational and health reforms, professional nurses have experienced changes in roles and responsibilities (Flores & Weintraub, 1998). Moreover, professional nurses' own perceptions and their public image have been shaped by the media and by the new market dynamics. Of interest in this research is the extent of the influence, if any, of the employment context (public and private) or the education system (public and private) on the creation of nurses' identities and responsibilities and thus on their claims to professional status.

Professional nurses have been in short supply, with an estimated 4.2 per 10,000 population (Castillo, 1997). Evidence suggests that they prefer to work in private health care

facilities. Sociologists Hernandez and Weintraub (1998) concluded that "nurses in the public sector are more dissatisfied in their labor than those in the private sector" (p. 51). Despite a lack of information concerning the number of professional nurses working in the private system, there also seem to be differences in the ratios of professional nurses in the public and private systems in Chile. Moreover, some researchers have noted that nurses in public health facilities delegate much of the direct care to nursing assistants and aides, whereas nurses in private health facilities engage in such activities themselves (Flores & Weintraub, 1998; Lange, Chompre, & De Monterrosa, 1991).

Statement of the Problem

Little research and information are available on the differences between public and private health sector nurses in Chile. For example, although Hernandez and Weintraub (1998) focused on the job satisfaction of nurses working in each sector, what is not known is how nurses in each sector conceptualize their work and its relationship to professional practice. Flores and Weintraub described nursing practice levels and the kinds of functions of the nursing personnel with their different types of management models in the different health sectors, but no exploration of the effects of different ratios of professional nurses in the public and private health care systems has occurred. What is known is that some professional nurses in the private sector provide direct care, whereas those in the public system are more likely to supervise auxiliary nursing personnel and thus provide care at a distance (Hernandez & Weintraub, 1998).

Focus of the Study

In this study the focus was on how nurses in Chile articulate their understanding of professional nursing and how the context—private or public—in which they practise influences their professional relationships, roles, responsibilities, and identities. This problem was explored in relation to the overall structure of professional nursing in Chile, including a nursing presence in the administrative teams of health care agencies that employ nurses, the importance of nursing

organizations in Chile, and the legal framework within which nurses practice. These areas were addressed through the reviews of the literature and official documents, as well as through interviews and questionnaires with relevant nursing personnel.

The specific research questions were as follows:

1. How do professional nurses in Chile
   - choose their place of employment?
   - describe their practice?
   - describe what being a professional nurse means to them?
2. What do professional nurses in Chile
   - envision as the ideal future for professional nurses in Chile?
   - perceive as changes needed to achieve their desired future?
3. How closely do Chilean professional nurses' descriptions of their practice and their professional identity fit with the criteria of nursing as a profession?
4. How do Chilean nursing students and nursing professors articulate the extent to which nursing is a profession in Chile?
5. How does context, in terms of public or private health care or educational institution, influence patterns of responses provided by nurses participating in the research?

Although this research was primarily a case study that used qualitative methods, some questionnaire data were collected. A *professional nurse* for the purposes of this study is defined as a person who has graduated from a five-year bachelor's program in nursing. It is common in Chile to call such nurses professional. *Nursing students* are those persons enrolled in educational programs in nursing in a Chilean university. *Nursing professors* are nurses who work in nursing programs in a Chilean university. In Chile, both private and public universities provide undergraduate nursing programs.

Organization of the Thesis

This thesis is organized into nine chapters. The first chapter is an introduction to the research. Chapters 2 to 4 introduce literature relating to nursing as a profession, theoretical perspectives guiding the research process, and nursing in the context of Latin America and, more specifically, Chile. The research process is described in the fifth chapter. The findings are reported in chapters 6 and 7 and integrated with the substantive literature in chapter 8. In the ninth, and final chapter, connections to nursing practice, education, and research are suggested. A major challenge of the research was the need to pay attention to issues of language. The translation process used in the study is described in detail in chapter 5.

CHAPTER 2:

THROUGH A THEORETICAL LENS: WHAT IS A PROFESSION?

Determining the relevant literature to review posed challenges because a great deal of disparate content, both theoretical and substantive, appeared pertinent. Theoretical literature of interest included discussions regarding what it means to be a professional, the claims of nurses to a professional identity, and discussion of the basic tenets of critical theory, feminist theory, postmodernism, and poststructuralism. Additional literature was reviewed to situate the problem being explored in the international, regional, and national contexts in which nurses are now located, with the regional context being Latin America and the national context being Chile.

Knowledge from each area of the literature reviewed was used to determine what data to collect and to guide analysis and interpretation of findings. As well, the goal of this research is to further knowledge and not reiterate what is already known. Thus an appreciation of nursing and health care in Chile is critical. The Chilean context needs to be understood within Latin American and international trends.

Professions and Professionalism: Through the Lens of Nurses and Nursing

Nurses have long aspired to recognition as health professionals. What does this mean? Why is it important? The review of the literature suggested that acknowledgement of professional status confers prestige and confirmation of value in society. The concepts of professions and professionalism will be discussed and related to nursing as an occupation that has often been denied professional status but does, in reality, meet the requisite criteria in many national contexts. Application to the Chilean context will be discussed within the articulation of literature on the development of nursing in Latin America and in Chile. Much of the most salient literature was published in the 1970s, with less discussion of nursing as a profession found in nursing sources in recent years.

Defining Nursing as a Profession: Professions and Professionalism

The two concepts of *profession* and *professionalism* have emerged as a societal means of distinguishing some occupations from others. Although members of many occupations identify themselves as professionals, "perhaps no more than thirty or forty occupations are professionalized" (Wilensky, 1964, p. 141).

The notion of professions began in the 16th century in Europe, but the 20th century was a time of debate regarding the meaning and merit of the concept. Flexner (1915), who developed the first criteria for the classification of occupations as professions, suggested that a profession is based on intellectual activity, requires a considerable amount of knowledge and learning, has definite and practical purposes, has certain techniques that can be communicated, has an effective organization, and is motivated by a desire to work for the welfare of society. Coe's (1970) characteristics of a profession are similar but extend the criteria to include the notions of an extensive body of knowledge, a license to practice, and a mandate to set and monitor standards.

Freidson (1983) suggested that there are two complementary models of professions. The structural or "trait" model defines traits that professions hold in common. Millerson (1964) listed the essential features of a profession:

> Involves a skill based on theoretical knowledge; the skill requires training and education; the professional must demonstrate competence by passing a test; integrity is maintained by adherence to code of conduct and the service for the public good; and the profession is organized. (p. 4)

The "functionalist" model, dependent on the status and prestige due to specialized skills, comprises four professional behaviours that Barber (1963) identified as

> a high degree of generalized and systematic knowledge; primary orientation to the community interest rather than to self-interest; a high degree of self-control of behaviour through codes of ethics internalized in the process of work socialization and through voluntary associations organized and operated by the work specialists themselves; and a system of rewards (monetary and honorary). (p. 672)

Thus a profession may be defined as an occupation that provides a valued service to society with some authority to control services and membership based on the attribute of specialized knowledge.

Nevertheless, in the development of occupations that desire to achieve the status of profession, there is a certain competence that needs to be fulfilled at a somewhat higher level than in other occupations. In order to achieve the status of profession, an occupation must comprise specific attitudes and characteristics, such as the adherence to organizations, a belief in self-regulation with its own standards of practice, and the autonomy to make decisions concerning practice (Hall, 1982, p. 93). Accordingly, in pursuit of these characteristics, professionals can also expect certain privileges in society, which include better salaries (economic), social recognition (prestige), and power of self-control (self-governance). With these benefits, some occupations claim to have the same privileges and status as professions; however, Becker (1962; as cited in Bennett & Hokenstad, 1973) contended that "a profession is nothing more than an occupational status symbol, which is put to use either in attempt to bring about social mobility for an aspiring group, or to protect established groups from interlopers" (p. 27).

From another perspective—within a division of labour and economic class structure—Larson (1977) stated that professions have translated the special knowledge and skill of their disciplines into social and economic rewards. As a result, the author noted, "it implies a tendency to monopoly: monopoly of expertise in the market, monopoly of status in a system of gratification" (p. xvii). Thus, in contemporary societies the increasing authority and status to which some professions aspire are related to occupational structure based on market power. Larson also referred to professionalism as the "process by which producers of special services sought to constitute and control a market for their expertise" (p. xvi). Consequently, Larson distinguished a profession from an occupation in that the former has three dimensions: (a) cognitive (knowledge and skills), (b) normative (service orientation and ethical principles), and (c) evaluative (characterized by autonomy and prestige). The cognitive and normative

professional dimensions are guaranteed by educational preparation in universities. The evaluative dimension, however, is provided through society in terms of prestige and authority, which are seen in the autonomy to control their groups, training, and legislation. Therefore, professions differ from other occupations not only in their characteristics or attributes, but also in privileges granted them by society (Swerdlow, 1984).

Other occupational groups striving to win such privileges have been labelled as *semiprofessions*. For example, teachers, nurses, and social workers have been labelled semiprofessionals (Adams, 2003; Etzioni, 1969; Lewis, 1973; Stuart, 1981). As Etzioni explained:

> a group of new professions whose claim to the status of doctors and lawyers is neither fully established nor fully desired, . . . their training is shorter, their status is less legitimate, their right to privileged communication is less established, there is less of a specialized body of knowledge, [and] they have less autonomy from supervision or social control than the professions. (p. v)

Nevertheless, there is a more optimistic vision of semiprofessions in the professionalism process (e.g., Kleingartner, 1967). According to Etzioni, from a gender perspective within male-dominated professions, some reservations have to be noted. For example, exploring the relationship between professions and patriarchy, Witz (1992) observed, "Gendered forms of exclusionary strategy have been used to secure men privileged access to rewards and opportunities in the occupational labour market" (p. 46). As a result, there is an impact of patriarchy on occupations staffed mainly by women workers and labelled as semiprofessions (Hearn, 1982). For example, Tang and Smith (1996) pointed out that the roles of women and minorities in American professions are an emergent issue because they are still fighting for equal employment and professional rights.

Because of the high value placed on autonomy in the definition of what it means to be a profession, this concept will be discussed in detail. In practice, autonomy exists when the members of an occupation define and regulate the nature of the service offered through control of

recruitment, certification of members, and standards of adequate practice. *Autonomy* derives from the Greek word "*autonomos*," meaning self-law (Ballou, 1998, p. 103). For some professionals, autonomy is considered the hallmark of professionalism; for those who practice autonomously, their practice is independent, self-actualized, and accountable (Henry, 1993). More specifically, those who have autonomy are those who exercise the principles of competence or capacity, decision making, critical reflection, freedom, and self-control (Ballou, 1998). Professional autonomy, then, is "the practice of one's occupation in accordance with one's education, with members of that occupation governing, defining and controlling their own activities in the absence of external accounts" (Schutzenhofer, 1987, p. 278). Thus, in the workplace, as Dwyer, Schwartz, and Fox (1992) affirmed, autonomy can be seen as "the degree to which the job provides substantial freedom, independence, and discretion to the employee" (p. 17).

In the process of achieving professional autonomy, however, some internal and external forces can create tension. As noted by Larson (1977), a contradiction can result between professional autonomy and the bureaucratic principles of authority. That is, there may be conflict between personal professional expectations of autonomy and those of a bureaucratic manager that may lead to strained relationships between the peer group with its self-regulation and the external control exerted by the bureaucratic hierarchy of the system. These forces can affect professional autonomy with potential conflict between loyalty to the organization and loyalty to the professional community. Therefore, self-regulation is problematic in terms of the corporate body of the professions. As Coburn (1999) explained, "Professional self-regulation, the measure of autonomy, implies not only that occupational organizations represent the profession externally and are not subject to outside control, but that the occupation itself and no one else, control the work of individuals practitioners" (p. 28).

Having autonomy is vital to having accountability—"the willingness to anticipate the results of one's actions and, in the light of those results, to act and to be held accountable by

one's peers for those actions" (Snowdon & Rajacich, 1993, p. 5). People have accountability because they have responsibility, authority, and the resulting autonomy.

Professionalism, as Johnson (1972) noted, is a peculiar type of occupational control that differs from professionalization because the latter refers to "the dynamic process whereby many occupations pass through predictable stages of organizational change, the end-state of which is professionalism" (p. 22). In the division of labour, the tension between institutions and occupations is extended by changing power relations. It is debated whether the norms of professionalism are compatible with the norms of collective bargaining. On the one hand, Larson contended that occupations striving to be accepted as professions will themselves tend to reject collective bargaining; Swerdlow (1984) purported, on the other hand, that some positive correlations exist between professional orientation and measures of militancy and participation in union activities and strikes.

As a result, creating professional organizations is an attempt to sustain uniform interests among members and promote uniform policies by imposing a monopoly on practice in the field. Through professional organizations, occupations maintain a sense of identity, colleague loyalty, and shared values (Johnson, 1972). The professionalization process is closely related to the unionization process: Members of an occupation seek to achieve collective upward mobility. There is, however, an important distinction between unions and professional organizations: Unions are more oriented to protection of their members collectively, and professional organizations are more oriented to protection of the public interest. Haug and Sussman (1973) observed that both processes are "contending processes in the struggle of occupational groups to achieve work autonomy on the job and parallel recognition of status among the public" (p. 100).

Whatever the categories and conditions of professions and semiprofessions, four areas of analysis seem key in their determination. According to Turner and Hodge (1970), these critical elements are the degree of substantive theory and technique, the degree of monopoly over professional activities, the degree of external recognition, and the degree of organization. These

authors elaborated on indicators that can be used to assess the degree to which each of these criteria is met by a profession. Indicators of professions will be addressed within the context of nursing in general and within the Chilean nursing context.

Development of Nursing as a Profession

The development of nursing as a profession can be traced as an historical and socioeconomic process from Nightingale's time to the present. Contemporary nursing practice is facing expanding roles in a variety of new types of work opportunities, but it is still not clear how professional nurses are dealing with these changes or what they may mean. As Styles (1983) asserted, for "a profession to be self-regulating and to develop and transmit the requisite knowledge and skill, its education, credentialing, organization, and practice components must evolve in substantial synchrony" (p. 572). Therefore, nurses have to critically examine the forces that have shaped and influenced professional nursing (Bent, 1993). Accordingly, as Roberts, Cox, Baldwin, and Baldwin (1985) reported, the system has changed in the last few decades through "dramatic change to the health care industry, and the nursing profession has been profoundly affected by these as well as the ongoing changes in women' work roles" (p. 22).

In terms of changes in health services, Styles (1983) questioned whether nurses have really increased their areas of specialization and salaries. Do nurses really have higher positions and better work schedules in the different types of institutions, public and private, in which nursing is practised in the United States of America? In the management literature, there is an increasing interest in the topics of power and empowerment in nursing practice. Despite more emphasis on the potential of technology and managed care to expand nursing practice, professional nurses are still striving to become autonomous and have control over the profession. In the case of the work environment, as Gordon and Wimpenny (1996) affirmed in their study, managerial hegemony of the market forces strongly influenced nursing teachers, who were affected by emotional distress and a crisis of identity in an educational setting in England. The

hegemony of the new management culture, according to Gordon and Wimpenny, "creates a situation where the values and priorities driving educational activity are based on an ill-fitting reductionist paradigm overly concerned with quantitative measures of productivity and cost-efficiency, often to the detriment of person-centred educational practice" (p. 484). As a result, there are increasingly complex challenges in the nursing profession related to the competing demands of fiscal accountability and high-quality personalized care. In times of fiscal constraint, the nursing personnel required to provide high-quality individualized care may not be available. To articulate where nursing fits with regard to the key determinants of a profession, the four critical elements that Turner and Hodge (1970) outlined will help to organize the discussion.

Degree of Substantive Theory and Technique

Being a profession implies that within the occupation there is an essential underpinning of abstract principles which have been organized into a theory, set of theories, or theoretical orientations with a set of criteria, standards of competence, and judgments concerned with the social desirability and utility of occupational activities (Turner & Hodge, 1970). If an occupation aspires to full professionalism, as Goode (1969) claimed, "It must be able to offer its control over a more substantial body of codified, applicable knowledge than that controlled by other occupations" (p. 281). There is no doubt that nurses have been trying to develop their own knowledge in different ways through each stage of the historical development of the profession to achieve autonomy and prestige. The evidence of professionalism in nursing has been explicitly developed through educational progress in generating knowledge in the discipline through a variety of degree programs, nursing standards concerning certification and accreditation, and other regulations at the educational level. As well, substantial research has been generated in recent years.

From the 1960s until today, nursing as a discipline has developed theoretically through the pursuit of a unique and defined body of knowledge. As a result, nursing is becoming a scientific discipline. As Johnson (1959) argued, "Certainly no profession can long exist without

making explicit its theoretical basis for practice so that this new knowledge can be communicated, tested, and expanded" (p. 291). Nursing theory development has been extensive; however, it has also been controversial with respect to nursing science having its own domain (i.e., applied, basic, or practical). As Wilensky (1964) noted, "Knowledge or doctrine which is too general and vague or too narrow and specific provides a weak base for an exclusive jurisdiction" (p. 148). Therefore, nursing education, as a central part of the establishment of the professionalization of professional nurses, has gone through a long process to develop uniform curricula and standards to achieve consensus about the requisite level of preparation. At this time there is a need for the further development of a unique body of nursing knowledge so that stronger nursing education programs can be created. As well, nursing is moving its programs to a higher educational level through baccalaureate, master's, and doctoral programs in institutions of higher education.

Nursing faculties in many countries have limited autonomy and little exclusive knowledge at the level of higher education in universities, particularly when they are considered departments within multidisciplinary health sciences or medical schools. With experience as a dean within a traditional physician male-dominated administration "who control the standards of nursing education," Torres (1981) suggested that "achieving actual autonomy and accountability for nursing may be close to impossible and often depends on the personalities involved" (p. 10). In the case of nursing students who learn a holistic view of nursing care but who face a different reality in hospitals, progression to a professional nursing identity is likely to be ambivalent and involve conflict. As Simpson, Back, Ingles, Kerckhoff, and McKinney (1979) concluded, "The contradiction between the professional ideas of their school and the bureaucratic realities of hospital nursing, if faced by the students, was resolved in favor of the hospital" (p. 234).

Moreover, the development of professional identity through professional socialization is an essential process gained through nursing education and practice. As Olesen and Whittaker (1970) described professional socialization, it "is the process of shaping individuals to fit the

needs of the profession and by implication of society" (p. 190). *Nursing identity* refers to the individual nurse's perception of her/himself in the context of nursing practice. It is both an external and an internal process, and it is described "as an experience and feeling of being a nurse" (Ohlen & Segesten, 1998, p. 722). McDonald (1999) recognized some external forces that lead to nurses' lack of identity: "their historical role as handmaiden, in the hierarchical structure of health care organizations, in the perceived authority of physicians over nurses, and hospital policies and the threat of disciplinary action" (p. 36). Basically, from a feminist perspective, nurses as women workers have been oppressed, and this can explain why they have been powerless (Fulton, 1997; Gordon, 1992; Roberts, 1983). Therefore, nurses must be conscious of the close but ambivalent relationships between nursing education and nursing practice. Without collaboration among nurses in both areas, the power of nurses to achieve professional goals may be diminished.

Degree of Monopoly

The degree of knowledge and skill that occupations require is sometimes described as closed and is related to the monopoly that they can exert over their professional activities. As Turner and Hodge (1970) purported, "Claims to knowledge and skills are usually closely linked with claims to some degree of monopoly over occupational activities" (p. 27). A monopoly involves both ideological and pragmatic aspects. First, at the ideological level, a monopoly over professional activities involves the exclusive possession of knowledge and associated techniques (Turner & Hodge, 1970). It is extremely unlikely, however, that any group will be able to enforce a claim to have a complete monopoly over the full range of activities to which it lays claim, especially in the health care system.

Nursing necessitates some types of standardization through accreditation in the institutional nursing programs and certifications for jobs such as the use of credentialing in practice. Credentialing is the recognition of individuals who meet established standards in particular areas of nursing practice (Ross Kerr, 2003). Therefore, in the development of a nursing

profession monopoly, there is also an increasing need to improve the registration of professional nurses and mandate licensure into nursing practice. For example, at the practical level of the profession, Ross Kerr (2003) recognized the vital requirement through Canadian nursing history "to ensure that nurses were graduates of recognized schools of nursing, but also that professional standards were needed to regulate nursing education and practice" (p. 416).

From a feminist perspective, however, professional nurses as women workers can be seen in terms of gender inequity in relation to other professions and legal systems. Therefore, an ideological monopoly has been limiting. For example, Fagin and Diers (1983) noted that "nursing is a metaphor for the class struggle, and now for the struggle of women for equality" (p. 26). Others, as Hearn (1982) contended, argue that patriarchy is oppressive and leads to a situation in which "semi-professions act as the handmaidens of professions in performing specific duties" (p. 198). Moreover, others have suggested that nursing is still in transition between vocation and profession, particularly as portrayed in media images and as perceived by the public (Campbell-Heider, Allen, & Dewey, 1994; Cleland, 1971).

At the pragmatic level it is necessary to inquire into the nature of the core techniques and applications of the claimed professional knowledge. Turner and Hodge (1970) included factors such as whether the organization of the workplace allows the performance of occupational activities; for example, the adequacy of material resources and facilities, as well as communication channels and how they are used. In the application of professional knowledge and techniques, nurses must have the appropriate resources and facilities. Therefore, there is an increasing need for professional nurses to emphasize empowerment issues as tools to promote professionalism through education, management, and nursing practice. Working together, nurses must be models of increasing empowerment to strengthen their monopoly over professional activities. For example, in the process of empowerment in management, Brown, Knight, Patel, and Pilant (1987) saw the power or control model as desirable, because nurses are distinguished by the amount of control that they exert over their own affairs and practices. As Moloney (1992)

claimed, "Power begets power" (p. 284). Therefore, nursing is still in the process of redefining its function in order to claim more monopoly over its services, likely because of its lack of power. From a feminist perspective, nurse managers and administrators in the workplace encounter contradictions. Miller (1998) noted that "there is the dichotomy between the need to *get the work done* or the labor role for nurses and the need to promote nursing autonomy and professional independence" (p. 210). The process of empowerment, however, can be possible only when nurses can assimilate the different levels of oppression into a positive identity of the profession (Roberts, 2000).

Degree of External Recognition

Public recognition is a multifaceted phenomenon. Nurses can be seen through the lens of individuals, co-workers, patients or clients, other occupational associations, employing units, government bodies, or administrative agencies engaged in the regulation of practices and other types of social organizations (Turner & Hodge, 1970). People can directly or indirectly evaluate professions through classification and their images of the specific professions. As well, the media often portray biased social stereotypes by using symbolic meanings that can enhance or diminish social power (Muff, 1982).

The identity of nurses has regularly been stereotyped in the media. Kalisch and Kalisch (1987) identified five dominant stereotypes of nurses: the angel of mercy, the girl Friday, the heroine, the mother, and the careerist. According to Hallam (2000), in the public perceptions of the 1990s, "images of nurses circulate in a public sphere increasingly dominated by the private interest of multi-national capitalism" (p. 177). Moreover, an appropriate individual self-concept as a professional is also significant. Strasen (1989) noted, "As more nurse leaders develop strong positive self-concepts, they can role model professional thinking and accountability" (p. 5). Therefore, nursing's self-image is also vital and influential for the communication of potential professional contributions to patients, clients, managers, and the general public. As well, Campbell-Heider et al. (1994) surmised, "On an individual level, nurses must recognize how

themes related to female socialization, societal stereotypes about women, and oppression permeate their own self-image" (p. 228).

Societal acceptance of the nursing role of advocacy on behalf of the patient would provide evidence of the public's recognition of nursing as a profession (Donahue, 2000; Manthey, 2000). Thus in 1973 the International Council of Nurses (ICN) included the concept of nurse advocacy in its code (ICN, 2004). *Advocacy* comes from the Latin word *advocatus*, meaning "who is convoked to give evidence." Specifically, Chaefy, Rhea, Shannon, and Spencer (1998) noted, advocacy is related to patients and public rights, includes the protection of patients from illegal practice and incompetent practice, and involves a defence of the clients' rights. In general, Carlson (2000) argued, "Advocacy, defined for healthcare as representing the needs of patients, is a core value within a nurse's practice" (p. 8). With respect to advocacy, some contradictions can be expected when the power structures of institutions limit and restrain the actions of professional nurses in their role of advocate for patients' rights. Therefore, conflicts can occur between managers and nurses, physicians and nurses, and nurses and nurses, especially when nursing practice is made vulnerable through the desire for profit and efficiency in the health care markets. In this sense the degree of external recognition of professional nurses is affected by external forces. Advocacy is a contentious issue in nursing. As employees, do nurses have primary responsibility to their patients or to the institutions that employ them? The answer is not always clear in practice.

Degree of Organization

Attention is focused on the organizational aspects of professions because organizations are the primary means of both exercising control over and providing access to basic occupational resources. Therefore, formal occupational associations raise two questions: First, how are they structured? Second, what are the occupation-related activities with which the associations might in theory concern themselves? Organizations in the profession of nursing are viewed as having a high degree of importance, because, as Johnson (1972) declared:

> The major collegiate functions of the occupational group are carried out by a practitioner association and attempt to sustain uniform interests among the members and promote uniform policies by imposing a monopoly on practice in the field and regulating entry to it. (p. 54).

Associations play important roles in areas such as the image of nurses, nursing practice, work-life affairs, certification, and the direction taken in developing programs in nursing education, research, and administration (MacPhail, 1994). The development of nursing organizations has varied from country to country. As early as 1899 nurses worldwide sought to unite and formed the International Nursing Council. The International Council of Nursing (ICN) is a federation of national nurses' associations (NNAs) that represents nurses in approximately 120 countries (ICN, 2004). Among its various roles, the ICN has exercised leadership in promoting nursing in most countries and has urged the creation of chief nursing officer (CNO) positions in national health ministries. In 1933 at the Paris-Brussels Congress, a resolution "that the ICN stress that a Department of Nursing is a valuable part of the Ministry (or Department) of Health and urge that such a department be established in all countries was adopted" (Splane & Splane, 1994, p. 81). There were CNOs in 98 of the 173 countries listed by the Human Development Report for 1993. Most countries in South America are among the nations still lacking a Department of Nursing within the Ministry of Health (Splane & Splane, 1994). Since 1953 nurses have also created their own code of ethics, which has been approved by the ICN and used by nursing associations worldwide (ICN, 2004). Today the ICN still provides the foundation for ethical nursing practice throughout the world, which includes standards, guidelines, and policies for nursing practice, education, management, research, and socioeconomic welfare (ICN, 2004). As well, nursing associations are the main professional organization for nurses in each country, and they play a vital role in regulating memberships within the profession. Therefore, the degree to which professional associations are mandated by law to regulate members and establish scopes of practice is a key indicator of the extent to which the occupation can be seen as a full-fledged profession. Variations are found from country to country, thus indicating various levels of

professional development in nursing depending on the national context in which nursing education and practice unfold.

Because of external forces, nurses are also related to other professionals, health care staff, and decision makers in the labour environment. Thus, nurses must negotiate carefully with other groups in the health care system. Collective action in the case of health care workers involves the concerted and organized efforts of individuals working together for common goals such as higher pay, better working conditions, and effective participation in the determination of patient care policy (Eldridge & Levi, 1982; Kalisch & Kalisch, 1982). Some nurses desire the benefit of being in unions and negotiating through collective bargaining. According to McClelland (1983), "The nursing literature of management on labor relations in health care organizations implicitly assumes that collective bargaining by professional nurses is undesirable" (p. 36). In hospitals, unionization can cause conflictive interrelationships between nursing administration and staff. It may also, however, provide "an opportunity for the nursing profession to exercise control over nursing practice by providing mechanisms to redistribute power within the health care organizations" (Cleland; as cited in McClelland, 1983, p. 37). Further, from a feminist perspective, nurses' struggles in negotiations between management and employees have resulted in unionization because of the power differentials between the two groups related to gender and class distinctions. For example, in a study of unionization, Breda (1997) noted that nurses as women and workers have used "unionization as a mechanism to collectively act to change work conditions in a rigid paternalistic system" (p. 107). In Canada, Coburn (1988) explained the benefits of unionization and collective bargaining in the 1970s and 1980s through the process of professionalization: "Nursing associations and nursing unions are being used both to increase occupational self-regulation and to gain control over the nursing labor process" (p. 453).

Reflections on Nursing as a Profession

Today, in general, nursing as a profession has achieved systematic and more standardized educational programs, licensing laws, professional associations, codes of ethics, and research and theory development, as well as a commitment to social values. Nevertheless, professional nursing is not yet recognized as having the high status of a full profession (Moloney, 1992). Governance in organizations comprises such forces as control, influence, power, and authority (Hess, 1998). Nursing's self-governance has been an important goal of nurses that is perceived as critical to achieving more autonomy, accountability, and authority in the field (Boughn, 1988; Pankratz & Panktraz, 1974; Schutzenhofer, 1987).

In the professionalization process of nursing, the development of specialized knowledge is vital to the legitimization of authority and autonomy over the profession. Autonomy is defined as one of the main markers in the nursing desire to achieve professional status because, as Batey and Lewis (1982) stated, it involves "the freedom to make prudent and binding decisions consistent with the scope of practice and freedom to implement these decisions" (p. 15). Thus, efforts to attain autonomy have been seen as positive and beneficial for nurses (Finn, 2001; Kennerly, 2000; McParland, Scott, Arndt, Sasson, & Garrel, 2000). But, for some authors, the nursing profession historically has been composed of a group of women workers in a structurally subordinated role, and nurses have always lacked the stability and autonomy that characterize professional practice. As Fulton (1997) lamented, "Autonomy was seriously limited by unequal relationships with medical staff" (p. 534). Studies have shown, however, that autonomy in nursing practice is constrained by both external and internal forces (Henry, 1993; Perry, 1986; Schutzenhofer, 1988; Wood, Beth, & Abraham, 1986).

Scholars have thus connected autonomy in nursing with accountability and authority (Batey & Lewis, 1982; Snowdon & Rajacich, 1993). Making a distinction between autonomy and accountability, Batey and Lewis defined *responsibility* as a charge for which one is answerable and *authority* as the rightful power to fulfill a charge. As a result, Snowdon and Rajacich argued,

"in order to be accountable, a nurse must have autonomy of action, and the authority to act within a defined nursing role" (p. 6). But nurses can be more accountable only when responsibility and authority are given to them and accepted by them so that they can plan, implement, and evaluate the care that they give. Hence, the degree of accountability is limited to the individual nurse's degree of authority (Blanchfield & Biordi, 1996). Consequently, once nurses have defined authority as the rightful power to fulfill responsibilities, autonomy allows the freedom to exercise that rightful power. This freedom derives from two sources: from the organizational structure and from the individual professional (Batey & Lewis, 1982).

Nevertheless, accountability related to responsibility and the rightful authority in organizations such as hospitals can be problematic. The authority of professional nurses in organizations can be threatened, and "conflicts related to the exercise of authority in nursing organizations appear to arise when formal description of positions delineate responsibilities (charges) that are recognized for a position but do not delineate the accompanying authority for that position" (Batey & Lewis, 1984, p. 14). A bureaucratic medical orientation in hospitals can diminish the nursing role to that of a paramedical position. However, as Rhodes (1983) declared, "In this century it has been considerably strengthened by the increase in high technology medicine and by the notion that the nursing role may be extended by taking more medical tasks" (p. 66). This medicalization of nursing weakens the definition of nursing as a profession when nurses have "accepted responsibilities assigned by external sources without questioning whether a responsibility was appropriate for professional nursing" (Batey & Lewis, 1982, p. 14). The dilemma occurs when the assumption of new responsibilities has consequences for the development of unique professional nursing roles. It can be a more contentious issue when related to the dynamics of a health care system based on efficiency and profit. There may be little room for nurses to negotiate.

Nurses are expected to be accountable to themselves, to the patients, and to other care workers and professionals, particularly those who are perceived to be a powerful source of

authority within health care agencies. In striving to be accountable in the work environment, with the rightful authority and freedom to act and decide consistently with responsibility and authority, nurses are exposed to continual external forces, especially in relation to supervisors, physicians, managers, bureaucracy, and agencies. According to Styles (1985), nurses must act to assume their legitimate accountability with political activism and legislation of their practice by government. Canadian activism through CNA has been widely reported. Because of the changes in the health-care system, increasing the political awareness of nurses is a main strategy. As Rodger (CNA president, 2000-2002; as cited in Ross Kerr, 2003) noted, "Our challenge is to exercise our power and influence and use the political process to help bring about a major change in the delivery of nursing services to the society" (p. 252).

Therefore, changes in society and in the health care system have forced the nursing profession to create new strategies to achieve more professionalism with greater autonomy and accountability. Self-governance is perceived as critical to the struggle. In pursuing self-governance, professional nurses have had to recognize that oppressing forces have affected their image of themselves; the development of nursing knowledge; the ability to create, maintain, and foster strong professional associations and collective bargaining organizations; and, finally, the ability to achieve autonomy. Therefore, is nursing a profession? The most correct answer may be a guarded yes, qualified by national, employment, and personal contexts. Assessing the degree of actualization of nursing as a profession in Chile was a goal of this research and is explored in later chapters.

CHAPTER 3:

THEORETICAL PERSPECTIVES: WHAT CAN SOCIAL THEORY, FEMINIST THEORY, POSTMODERNISM, AND POSTSTRUCTURALISM CONTRIBUTE TO THE ENDEAVOUR?

Academic nursing has borrowed heavily from social theory in the development of nursing theory and in the application of conceptual frameworks to describe nursing issues and nursing practice. Conceptualization of the approach to the research problem outlined in this dissertation includes guidance provided by critical theory (CT), feminist theory (FT), postmodernism, and poststructuralism.

Critical theory and feminist theory are two types of theories related to oppression that involve class, race, gender, and culture. The analysis of the process of domination through critique and consciousness of the oppressed forces is the key methodological aspect of critical theory. As Morrow and Brown (1994) explained, critical theory may be viewed "as an approach to the sciences, as a conception of society, and as vision for realizing certain values" (p. 7). CTs differ from FTs because the emphasis in FT is on gender rather than class inequalities. Both, however, share common purposes: a liberation from domination. Both theories can be useful in understanding professional nurses as an oppressed group because they are related in their discussions of gender and class in the institutions of the social bureaucracy.

Postmodermism is a cultural movement marked by statements about the multinarratives of reality, subjectivity, and the rejection of universal truth. Therefore, by using language, symbols, and discourses, oppressed people can raise their voices and become more visible. From a poststructuralist view, the relation of power and knowledge and discourses is seen in arrangements of various forms of group resistance to domination. Politically, postmodernism and poststructuralism can be used as intellectual tools to strengthen the rejection of the dominance of

oppressive capitalism. Thus, professions such as nursing can have a greater awareness of the effects of market forces in their attempt to develop professionally.

Critical Theory

Critical theory is a social theory that addresses the oppressive effects of society on its members. The roots of CT are developed in the 1930s through the philosophical movement associated with the Institute of Social Research, or the Frankfurt School (Scott, 1978). CT is based on meta-assumptions that were derived from Hegel's dialectics and modified by Marx's critique (Stevens, 1989). The main goal of CT has been to create a life free of all forms of oppression or unnecessary domination. As Horkheimer (as cited in Allen, 1985) put it, "CT aspires to bring the subjects themselves to full self-consciousness of the contradictions implicit in their material conditions, to penetrate the ideological mystification and false consciousness that distorts the meaning of existing social conditions" (p. 62).

Critical theory is a complex group of theories. For example, the theory of false consciousness assumes that ideology portrays to people a false unity of the ideal and the real. CT, as Fay (1987) noted, "demonstrates the ways in which the self-understanding of a group of people are false" (p. 31). Through theories of crisis, CT is seen as addressing the contradictions between ideology and reality. According to Fay, this type of CT "requires examining the felt dissatisfaction of a group of people . . . and provides an historical account of the development of this crisis, partly in terms of the false consciousness of the members and partly in terms of the structural basis of society" (p. 32). CTs of education offer insight into conditions of enlightenment through self-consciousness (Freire, 1970). Theories of transformative action, as Fay reported, are "a plan of action indicating the people who are to be the 'carriers' of the anticipated social transformation" (p. 32).

The central methodology of CT is the "immanent critique" or critical review that involves examining the values and ideologies of social institutions and their extant reality to uncover

discrepancies between the two (Antonio, 1983). Therefore, the purpose of contemporary CT is to understand how people communicate and develop symbolic meaning, and by means of this process to uncover the distortions and constraints that impede free, equal, and unforced participation in society.

Critical theory has used the terms *domination* and *oppression* as interchangeable concepts to indicate unequal power relations. Gramsci's (1971) notion of *hegemony* describes oppressive power as the dominant power of the 20th century and the ways in which power is exercised. The critique of ideological hegemony is concerned with how power operations are involved through the cultural forms, the meanings, and the representations that provide consent to the status quo. The critique of ideological hegemony clarifies the understanding that dominant ideological practices and discourses have shaped people's vision of reality. As Kincheloe and McLaren (2000) pointed out, through

> understanding domination in the context of concurrent struggles among different classes, racial and gender groups, and sectors of capital, critical researchers of ideology explore the ways such competition engages different visions, interests, and agendas in a variety of social locales. (p. 284)

In the last part of the 20th century a branch of CT readdressed postmodernism and poststructuralism. Therefore, contemporary CT conceptualises "power" not only as an ideology but also as a "linguistic/discursive force" (Kincheloe & McLaren, 2000, p. 284). Thus, CT demonstrates that language is not a neutral and objective, true representation that describes the real world. For example, if social practice determines meaning in the context in which it is used, then discursive practices are, as Kincheloe and McLaren noted, "a set of tacit rules that regulate what can and cannot be said, who can speak with the blessings of the authority and who must listen, whose social constructions are valid and whose are erroneous and unimportant" (p. 284). Therefore, CT admonishes us to recognize the significance of power relations within discourse that will determine the meaning of language and the consequences of implanting hegemonic/ ideological messages into the consciousness of the people.

The critical approach includes a variety of perspectives sharing a common historical pattern of roots within resistance movements against different types of domination; for example, in developing countries with respect to people of colour, in Latin American and Caribbean women's collectives, and in feminist groups (Stevens & Hall, 1992). Therefore, CT is a sensible response to liberation from the oppressive circumstances of particular groups of people, including their culture, history, politics, and economic circumstances. In the field of nursing, CT has implications on several levels and has been used in a variety of approaches such as in conceptualizing emancipatory paradigms, in developing alternative frameworks for nursing education and practice, in offering professional empowerment, and in understanding institutional power in nursing (Fulton, 1997; Hedin, 1986, 1994; Kim, 1999; Mason, Backer, & Georges, 1991; Stevens, 1989).

More specifically, Thompson (1987) maintained that a critical perspective "presents an alternative message to nursing in the systematic, continuous critique of domination" (p. 28). The implications for professional nursing are situated in the social and historical context in which nurses are practising, such as health institutions with a medical care model. Moreover, by using the term *professionalism*, CT implies that it has been used as an ideology of positive attributes that legitimize class divisions in the social world. As Allen (1985) stated, professionalism is a monopolistic territory that is obscured by the ideology of service and quality care. CT has helped the field of nursing to analyze how the organization of the nursing profession perpetuates and disguises power imbalances and suggests that nursing education practices often cause future nurses to adopt values and behaviours that minimize their ability to engage in critical reflection. Therefore, CT helps nurses to develop greater awareness regarding perceptions of the world as situated in a social and historical contextual reality.

Feminist Theories

Feminist theories are those that pertain to the observed inequality of the sexes in terms of status and the division of labour that exists because of gender differences. Feminists conceive of patriarchy as a structural problem for women that has been ignored in social theory. Early feminist theories focused on explaining the origins of the condition of women and understanding those elements that perpetuate the mechanism behind those conditions related to sex roles (or sex differences) and status. Feminist theories are concerned in general with seeking an understanding of the gendered nature of virtually all social and institutional relations. This includes how gender relations are constructed and related to other inequities and contradiction in social life, why gender relations are not viewed as either natural or immutable but rather as historical and social products, and why an explicitly political advocacy of social change is necessary (Mandell & Elliot, 1998). FT has advanced as a potent epistemological and discursive set of arguments and includes assumptions such as the following: women's experience is a legitimate source of knowledge; the subjects' data are valid; the informants are experts on their own lives; knowledge is relational, contextual, and socially constructed; and the boundaries between personal and public or personal and political spheres are artificial (Campbell & Bunting, 1991).

The varieties of the first stage of feminist theories may be summarized in terms of the following perspectives. First, liberal feminism (LF) proposes equal rights and opportunities for women relative to men. As Pohl and Boyd (1993) revealed, "The inequality of women stems from the denial to them of equal rights and from their learned reluctance to exercise such rights" (p. 198). LF means that women can improve their positions in the family and society through a combination of individual initiatives, rational discussion, and laws protecting women against discrimination.

Second, socialist feminism (SF) views, first, economic conditions as the origin of women's oppression; Mitchell (1974) defined four basic structures: production, reproduction,

sexuality, and socialization of children. Therefore, SF's objective is to transform the basic structural arrangements of society such as class, gender, and race.

Third, radical feminism (RF) emerged in the early women's liberation movements of the 1960s. Radical feminism analyses the oppression of women within all types of economic systems and cultures in terms of patriarchy. Patriarchy, as Eisenstein (1999) defined it, is "a sexual system of power in which the male role is superior in possession of power and economic privilege" (p. 202). RF sees men's dominance over women and male control of female sexuality as the main causes of women's oppression. Therefore, sex is seen as a status category with political implications (Millet, 1970). Most radical feminists view women's oppression as the first and deepest form of human oppression. Therefore, women's oppression provides a conceptual model for understanding all other forms of oppression. As hooks (2000) explained, "The exercise of power to end domination . . . was a central tenet of the radical movement" (p. 84).

A second stage of FTs is developed in postmodern feminist theory, which is derived from postmodern theory as a critique of modernity. Postmodern feminism questions the liberal idea of the subject, emphasizing instead the way in which forces outside the self constitute or affect it (Farganis, 1994). Agger (1998) asserted that postmodern feminist theory contends that "liberation is achieved through narratives, storytelling, which forms feminist identity and creates feminist culture" (p. 115). Another group of feminist and poststructuralist theorists are joined in poststructuralist feminist theory, which focuses on power and the social implications of power. Postmodern feminist theory emphasizes that both language and discourse are the most important elements in the analysis of social organizations, social meaning, and the relations of power and individual consciousness (Weedon, 1987). Poststructuralist perspectives are perceived by some authors as exchangeable, but as Nicholson (1994) distinguished them, postmodernism is used more as a philosophy and social theory, whereas poststructuralism is used more often in the context of literary criticism.

Feminism provides a framework for developing a worldview about concerns that affect women. Because nursing traditionally has been a woman's occupation, from a feminist perspective it is important to understand women's awareness. For example, women's problems are nurses' problems. In terms of health care, feminist research has helped to clarify women's issues. As Fee (1975) observed, the radical feminism approach rejects the health care system because it is originally based on the oppression of women. Webb (1986) thought that nurses should politically analyze feminism and nursing practice to develop a more feminist consciousness in their relations with physicians. In terms of professional autonomy, nurses still perceive themselves as lacking power and autonomy in a bureaucratic setting such as a hospital, because, according to Breda et al. (1997), "the pursuit of autonomy for all nurses in the hospital required that we introduce fundamental changes in the way nurses practiced through the hospitals" (p. 80). Therefore, feminist theories can improve nurses' understanding of the importance of autonomy, which includes greater participation in health delivery and an increasing consciousness of oppression.

Nursing has a history of submission and male domination. Vance, Talbott, McBride, and Mason (1985) cited Howe, a well-known feminist, who declared that the energy of feminist perspectives must be focused on "building their potential for strong leadership in nursing, teaching and social work" (p. 282). If nurses are considered in terms of powerlessness, nurses have had some undesirable characteristics that are typical of oppressed groups. As Chinn and Eldridge (1985) stated, "Traits recognized by nurses as undesirable include divisiveness, the low level of participation in professional nursing organizations, and a lack of effective leadership in nursing" (p. 77). Therefore, FTs are useful for nursing because they provide an understanding of women's oppression and their marginalized participation in society.

Postmodernism

Because modernism had its roots in a particular set of cultural or aesthetic styles associated with artistic movements that originated around the turn of the 20th century, postmodernism is seen as partly related to the contemporary development of new aesthetic and artistic forms that affect a variety of areas of cultural production. As Sarup (1993) explained, a characteristic of postmodernism is "a shift of emphasis from content to form or style, a transformation of reality into images; the fragmentation of time into a series of perpetual presents" (p. 132). Therefore, postmodernism is a complex cultural phenomenon that is based on its distrust of discourses concerning reasons and universal truth and emphasizing diverse forms of individual and social identity. Larrain (1994b) concluded that postmodernism "appears as an eclectic attempt to mix art and life, fantasy and reality, high and mass culture, codes and styles from different ages and cultures" (p. 290).

For some scholars, modernism and postmodernism are cultural formations that accompany particular stages of capitalism. For other scholars, postmodernism is equivalent to "the logic of the culture of late capitalism" (Wicke, 1992, p. 14). Thus, postmodernism is seen as the successor of aesthetic and political modernism, which still seeks to direct modernization into universally progressive directions (Jameson, 1991). Paradoxically, postmodernism seems to co-exist with neoliberalism; Larrain (1994a) proposed:

> Postmodernism connects with this latter aspect [neoliberalism], not so much with the rationality of the entrepreneur as with the irrationality of the market results. Thus it could be said that postmodernism has become the philosophical logic of neo-liberalism just as neo-liberalism has become the economic logic of postmodernity. (p. 118)

Postmodernism differs from postmodernity, according to Kermode and Brown (1999), in that "postmodernity seeks to prevent the social and political reforms necessary to achieve the worthy goals embodied in modernist society, such as the promotion of liberty and democracy, the eradication of poverty and oppression and a focus on the quality of life of populations" (p. 378).

Watson (1995b) believed that there is also a great deal of criticism of postmodernism. On one side, postmodernism is concerned with the deconstruction of reality, whether through analysis of language, knowledge, or power structures. Postmodernism provides linguistically transformed representations in which the unreal is constituted as the real and a virtual reality can recreate a surreal reality. On the other side, postmodernism involves the reconstruction of reality with the aim of emancipation from oppression, strict dualism, the domination of rationality, technological controls, and the knowledge discourse that has been thrust upon humanity since the dominance of modernity.

The postmodernist view is concerned with the crisis of legitimization and representation and thus the understanding of language as an ideological production with multiple subjectivities. By assuming the importance of discourse analysis, researchers can understand the way that language constructs realities that serve to support particular institutions or ideologies. For example, the study of nursing specialization can be analyzed by how the different discourses focus on power and knowledge relationships. Cotton (1997) claimed, "The discourse of specialization is resisted by, and is antagonistic to, the discourse of holism, . . . the discourse of medicine and the discourse of nursing: . . . [the] specialization versus collaborative model" (pp. 26-27).

Poststructuralism

Poststructuralism and postmodernism have been used interchangeably, but as Fahy (1997) noted, "They are not identical concepts. Postmodernism is a broader, more inclusive concept than poststructuralism" (p. 28) Poststructuralism differs from postmodernism because posstructuralists "do not hope any longer that meaningful change can be attempted and tend to dissolve reality into incommensurable language games and/or simulacra" (Sarup, 1993, p. 291). But in poststructuralism, as Palmer (1997) believed, "language, meaning, social institutions and the self are destabilized" (p. 145). The most notable poststructuralists are Derrida and Foucault.

Michel Foucault, the French philosopher, dissented from the linguistic determination of postmodernism and turned to the poststructuralist perspective that individuals are enmeshed by power relations, power being the ultimate principle of social reality (Sarup, 1993). As a poststructuralist, Foucault (as cited in Larrain, 1994b) did not "dissolve social reality into fragmentary images and signs and still [saw] the possibility for a variety of collective subjects to be politically constituted by progressive discourses which resist power or aim at socialism" (p. 290).

Foucault (as cited in Dickens & Fontana, 1994) described themes of power/knowledge and how they interact in practices of domination for the analysis of discursive intervention, regimes of power/knowledge, and technologies of truth in human behaviours. Foucault analysed modern rationality, institutions, and forms of subjectivity as sources or constructs of domination; and he noted the operations of power, particularly in the relationship between the production of knowledge and subjectivity. In *Discipline and Punish: The Birth of the Prison*, Foucault (1977), used the Panopticon (a metaphor of Bentham's design for a prison that would leave prisoners perpetually exposed to view and therefore likely to police themselves) to discuss a model for all forms of domination by using power as a disciplinary form. From a feminist perspective, as Deveaux (1996) noted, "The transition from sovereign authority to modern, disciplinary forms of power are seen to parallel the shift from more overt manifestations of the oppression of women to more insidious forms of control" (p. 214).

The relationship between power and knowledge, as Foucault (1977) argued, has an intrinsic correlation: Power cannot be exercised without knowledge, and it is not possible for knowledge *not* to engender power. Foucault also believed that the analysis of power should be concentrated not on the level of the conscious intention of the subjects, but on the point of application of power: "Power is something that circulates, that is never localized or appropriated as a commodity. . . . Power is everywhere; not because it embraces everything, but because it comes from everywhere" (Larrain, 1994b, p. 293). Therefore, Foucault's vision of power is

controversial because he conceived of power not in terms of repression or prohibition, but as something that produces reality: "We have to consider that the exercise of power itself creates and causes to emerge new objects of knowledge" (Sarup, 1993, p. 74).

The power of language, whether written or spoken, is used to identify and interpret signs. As Crowe (1999) emphasized, "Language as a system is a cultural form that owes its existence to a collectivity of participants who adhere to communal conventions in order to be understood" (p. 329). Thus, some signs privilege some meanings that are part of the dominant discursive practices. Scott (1990) asserted that, from a poststructuralist position, "knowledge is an effect of power and constituted in language. It is not subjects who have experiences but subjects who are constituted by experience" (p. 26). Therefore, professional nurses are related with patients, managers, physicians, and others, in different forms of discourse. For example, Heartfield (1996) examined the resulting hegemonic influences that have been constructed in nursing practice from written descriptions of patients: "The dominant power of institutional, scientific, medical knowledge and process are clearly evident in the way that nursing is mediated through the patient record" (p. 101). Horsfall and Cleary (2000) noted that in therapeutic patient-nursing relationships in a psychiatric institution, the nurse-patient relationship is less visible, and nursing responsibilities become blurred. The policy of required documents, however, reinforces the traditional medical hierarchy of power relations. Therefore, poststructuralism is useful for nursing because by analyzing the power and knowledge and discourse operations dominant in society, nurses are able to understand the oppressive forces within which they identify themselves as nurses.

Reflections on Selected Social Theories

Critical theory and feminist theories are theories related to oppression involving class, race, gender, and culture. The philosophical roots and theoretical perspectives of CT and FT are seen as two schools of thought related to the process and dynamics that involve the critique of

domination. Both introduce models and forms for exposing power and domination in our society. The general assumptions of CT and FT are that by understanding and critiquing ideologies, languages, and discourses, we can also understand the forms of social control and domination. In CT the central interest is emancipation through the process of enlightening groups of people, whereas FT is related to the description of women's lives and their emancipation through "consciousness raising," with the intention of freeing women from the oppression of patriarchy (Bent, 1993).

The emancipatory aspirations of CT and FT encounter some difficulty with postmodernism because only some forms of postmodernism serve the purposes of resistance and emancipation. It can be argued that collaboration with postmodernism has undermined both scientific and emancipatory aspirations. Fahy (1997), however, suggested that in an emancipatory study, "postmodernist notions of power and subjectivity are particularly useful to uncover the strategies and tactics of power, submission, and resistance" (p. 27). Therefore, theoretical understandings of power/knowledge relationships to enlightenment and empowerment can be developed. The difficulty with assuming a postmodern relativism in the discursive approach is the tendency that its analysis stresses the diversity that masks power differences. As a consequence, postmodernism deals with a number of problems inherent in postmodern theorizing. Because postmodernism is conceptualised in different ways across different fields of inquiry, there is still a disturbance. On one hand, it is seen primarily as focusing on technologies of information. On the other hand, postmodernism is considered as focusing on literary theory, history, and philosophy in a way that is close to poststructuralism (Fahy, 1997). Although Kermode and Brown (1999) felt that "the postmodern concept of discourses bringing general order to chaotic experiences is not different from metanarratives imposing an order of power" (p. 378), it is expected that postmodern theorists would disagree vehemently with this statement.

Postmodernism as a philosophy values social contextual experiences and the uniqueness of individuals and rejects generalization about those experiences. Postmodernism, however, is

also seen as a disinterested and intellectual amusement, "the opiate of the intelligentsia" (Fahy, 1997, p. 31). The enlightenment tradition of political thought is characterized by some epistemological features such as accurate objective accounts of the world, the neutrality of reasoned judgement, scientific objectivity, the progressive logic of reason, the omnipotence of reason, and, finally, the rejection of the importance of power to knowledge and, concomitantly, the denial of the centrality of systematic domination in human societies (Harstock, 1999). Postmodernists argue against the faith in universal reason that is part of the enlightenment tradition and propose a "social criticism that is contextual, plural and limited" (p. 40). Postmodernism challenges the enlightenment narratives or grand theories of modernity for failing to succeed in their emancipatory intent. But as Sarup (1993) recognized, postmodernism offers no theoretical reason to move in any particular social direction. In this respect, postmodernism "is not an agent of social change but an agent of social stasis" (p. 378).

From a feminist perspective, Fraser and Nicholson (1990) described the attraction for postmodernism in feminist theories because postmodernism opens up discourse to include a wide range of women, opposes the universalizing of arguments and positions, criticises objectivity, and recognizes the importance of language. On the relationship of postmodernism and feminism, Lather (1991) stated that "postmodernism both imposes a severe re-examination on the thought of the Enlightenment and is being inscribed by those who want to critically preserve the emancipatory within a framework sympathetic to postmodernism's resituating of that impulse" (p. 48).

Regarding how power relates to knowledge, the feminist literature contains analyses of Foucault's work on power. On one hand, Foucault's power paradigm of *Where there is power, there is resistance* is helpful for feminists because it shows the diverse sources of women's subordination as well as demonstrates that women engage in resistance every day (Deveaux, 1996). But, on the other hand, the notion of Foucault' s power paradigm, as Deveaux indicated, "obscures many important experiences of power specific to women and fails to provide a

sustainable notion of agency" (p. 222). In pursuing power, subjects must be free; however, domination is the result of trajectories of force and power relations that finish in subordination and no resistance. Therefore, the understanding of power is not only about subjects' objectives of resistance to external forces, but also about understanding the internal forces of a woman's feeling of empowerment in her specific context. Therefore, as Deveaux argued, "both the paradigm of power and the treatment of the subject that emerge from Foucault's work are inadequate for feminist projects that take the delineation of women's oppression and the concrete transformation of society as central aims" (p. 212).

Epistemologically, because postmodernism questions notions such as subjectivity, identity, agency, language, and voice, as Kermode and Brown (1999) affirmed, postmodernism is "a hoax concocted by white bourgeois patriarchy to divert women and other oppressed groups from participating in the Enlightenment project, while the real narrative rolls on relentlessly—capitalism, patriarchy, and power" (p. 391). Therefore, with these main tenets of postmodernism, critical and feminist theorists have good reason to be doubtful of the relevance of postmodernism, and the critique of postmodern theories must be assumed without losing emancipatory aspirations. For the purposes of this research, the often contradictory but also complementary insights generated through colliding ideas offered by CT, FT, postmodernism, and poststructuralism were an integral part of the intellectual milieu in which the data collection, analysis, and interpretation were pursued. Because professional status is equated with power, these theoretical approaches appear relevant for any thoughtful analysis of nursing as a profession.

CHAPTER 4:

NURSING IN CHILE IN THE CONTEXT OF GLOBALIZATION IN LATIN AMERICA

As a background to studying professional nursing in Chile, it is imperative that the international, regional, and national contexts in which nursing is emerging be considered. The argument for nursing as a profession has already been made. The international political, socioeconomic, and historical contexts in which nursing and health care are currently situated are discussed briefly; and a more detailed discussion of the cultural, health, and nursing contexts in Latin America, particularly in Chile, follow.

The International Context

At the beginning of the 21st century, economic, political, cultural, and social issues instigated many contradictory viewpoints. Some concerns relate to the impact of globalization and the liberation of free markets throughout the world; others relate to the increase of poverty and inequity. As Navarro (1998) pointed out, "Globalization of commerce, investments, and finance has become a major force in public policies, including health policies"; and whereas for some people this "has meant an unprecedented growth in wealth and income, for others the process has meant an unprecedented deterioration in their standards of living, health and well being" (p. 742).

Globalization incorporates political, economic, and social changes that have occurred in almost all countries, including the spread of liberal democracies, the dominance of capitalist market forces in an integrated global economy, and the transformation of production systems and markets with accelerated technological advances (Bettcher, Yatch, & Guidon, 2000; Yatch & Bettcher, 1998). It has also compromised social welfare safety nets by "reducing public deficits through the decline of public and social (including health care) expenditures, deregulating

financial and labor markets, and privatizing public enterprises and programs" (Navarro, 1998, p. 742). In pursuing these goals, governments have reduced their contributions to social benefits such as education and health care. Moreover, globalization involves not only economic changes, which create an international integration of production, but also transnational networks in communication and a universalization of values by using a neoliberal ideology as "a free-market doctrine" (Chomsky, 1999, p. 34).

Neoliberalism therefore is utilized as the political expression of many governments and institutions in their pursuit of economic globalization. With roots in economic liberal ideology, as expressed in the works of Hayeck (1941) and Friedman and Friedman (1962), neoliberal thinking converges into four basic elements: (a) the market's efficiency as a distributor of resources, (b) free competition as a dynamic activity, (c) the importance of self-regulated markets, and (d) the exclusion of the state from economic activities (Gonzalez, 1999).

Globalization during the 21st century has had a huge impact not only on the distribution of wealth, but also on the health of populations and the organization of health care delivery systems (Anderson, 2000). Berlinguer (1999) reported that "over the last decades . . . imbalances of income, power and knowledge among different classes, ethnic groups, genders and people have generally brought about growing inequalities in health standards" (p. 580). Thus we find in 1995 a world with a population of one billion people living in poverty, 800 million hungry every day, 240 million malnourished, and billions more suffering a lack of access to clean water and sanitation—the majority from countries of the south (UN Reports, 1995). In this century an increasing gap between rich and poor countries has caused contrast such as "at the same time that there are 170 million of children in poor countries who are underweight—and over three million of them die each year as a result—there are more than one billion adults worldwide who are overweight and at least 300 million who are clinically obese" (WHO, 2002, p. vii).

The nursing profession's central mission in providing care must essentially promote inquiry into marginalization; that is, with regard to class, race, gender relations, and poverty. Hall

(1999) contended that the central issue in nursing is marginalization because it encompasses the "peripheralization of individuals and groups from a dominant, central majority" (p. 89). Nurses today face increasing financial, legislative, structural, and institutional changes in the health care industry, with issues such as competition, efficiency, and free choice (i.e., public or private) being raised. Professional nurses should have an interest in the global context because transformations in the health care system have affected the health of people, labour relationships in health care settings, and nursing's own professional autonomy and values.

Latin American Context

Over the last three decades political changes from dictatorships to new ways of democratization have occurred across Latin America. New democratic governments in such countries as Chile, Uruguay, Colombia, and Peru introduced neoliberal policies in the 1970s; and in others such as Argentina, Mexico, Bolivia, Costa Rica, Guatemala, and Panama in the 1980s (Harris, 2000). The resulting social reforms have ignored social needs and annulled universal social policies relating to employment, wages, and health (Oliver-Costilla, 2000). The increasing gap between the poor and the rich is a direct result. The 1996 World Bank International Economic Report (as cited in Harris, 2000) revealed that "while the highest 20% of income earners receive between 40-70% of the total annual income in the Latin American countries, the lowest 40% of income earners only receive between 5-20% of the total income earned" (p. 139). Connections to the globalization process, "combined with the effects of the debt crisis of the early 1980s, the effects of these neo liberal policies have drastically increased the number of Latin Americans living in poverty" (p. 141). According to the Economic Commission for Latin America and the Caribbean (1995), in Latin America during the 1980s, 35% of the population were poor and 15% were indigent; whereas by the 1990s, 39% were poor and 18% were indigent. In general, except for the Chilean transformation and the success of the Mexican pact in the years prior to 1994, there has been little evidence of economic progress in Latin America (Krueger,

1999). Moreover, the Chilean experience has resulted in a high cost to social and welfare institutions and created great inequity.

Since the early 1980s in Latin America, neoliberal economic policies have been introduced through the Structural Adjustment Programs (SAPs) that have reshaped economies from government-regulated economies toward free-market economies. SAPs were prerequisites for obtaining loans from the International Monetary Fund (IMF) and the World Bank during the 1980s (Remmer, 1998). According to Sparr (1998), the main goal of the SAPs was to "create an open economy, a liberalization of prices, the decrease of public expenses, and an increasing privatization and promotion of exports" (p. 1). Thus SAPs were introduced in two phases:

- *stabilization*, in which the IMF makes loans to help countries overcome short-term imbalances in their current accounts if they agree to adopt demand-restricting measures, such as monetary restraint and cuts in public expenditures, as well as demand-substitute measures; and
- *adjustment,* in which the World Bank offers longer-term loans to countries consenting to deregulate their economies and make them more market-oriented, with an objective to improve economic efficiency and promote more rapid economic growth (Renka, 1991).

After more than a decade of reform, empirical evidence in Latin America shows that neoliberal reform as a strategy for managing economic crises is not an effective method. The reasons for SAPs falling short of expectations include governments' failures to implement reforms properly and overly optimistic projections among policy makers. Neoliberal programs have also been criticized because they require not only economic reform, but also an ideology in which the free market and the principle of cost benefit overwhelm all others in the field of human life (Navarro, 1998).

With regard to gender inequality, SAPs have also produced gender-specific costs in the sense that adjustment policies have involved cutbacks in social services, higher prices for basic

needs, and greater unemployment and job insecurity, thus exacerbating existing gender inequalities (Mies, 1998). The feminization of production, which concentrates on mainly low-wage, low-skill assembly production, has not been translated into a higher earning capability or standard of living for women. Examples include the predominance of female employees in *maquiladoras*, agriculture, and the informal labour sector (Alarcon-Gonzalez, 1999; Renka, 1991; Wilson, 1998).

In addition, public health care systems in Latin America have experienced significant reform. In what were historically strong public health care systems, governments have been privatizing and redistributing health services in terms of their structures, finances, and services. According to Bertranou (1999), a comparison of health insurance reforms in Chile, Colombia, and Argentina suggests that the reforms "have positive and negative impacts on equity and efficiency" (p. 30). The impact on public health and health sector workers has been the systematic rearrangement and distribution of the system through changes in financial support, the introduction of policies that strive to create efficiency, and the employment of fewer personnel to provide services. Indeed, the growing private sector has begun to recruit workers from the public health sector, and the demand/supply relationships in the two sectors have been altered in the last decade, although a lack of information exists about the changing labour conditions of the workers.

Professional Nursing in Latin America

During colonization by Spain and Portugal in the 16th century, Latin America developed a minimal health system infrastructure. Subsequently, after independence in the 19th century, the initial focus was on basic sanitation and control of infectious diseases. With the development of medical and nursing services occurring mainly in asylums and charity hospitals run by religious congregations, nursing did not receive much emphasis until the 20th century (Verderese, 1979). With the emergence of nursing care and medicine, nursing was perceived within the traditional

roles of women as a "subordinated profession" to physicians. The development of professional nursing education began in Buenos Aires in 1890, in Cuba in 1900, in Chile in 1902, in Mexico in 1907, and in Uruguay in 1912 (Infante, Alvarez, & Lanzabal, 1992). Between 1900 and 1960, Latin America began the process of industrialization with higher aspirations for education and health for the population. Nursing staff were perceived as essential to the development of healthy populations. Consequently, the nursing profession was increasingly advanced through implementing government policies that supported building nursing schools, advocating more holistic conceptualizations of health, focusing on disease prevention through hygiene and immunizations, and valuing the potential contribution of professional associations (Verderese, 1979). The pace of the development of hospitals and medical services increased, along with the number of nursing services, nursing schools, and nurses in professional practice. During this period, according to Infante et al., "education was considered one of the main tools to achieve modernization with a higher specialization" (p. 86).

From the 1960s to the 1990s health care systems and nurses were involved in a variety of crises that included dictatorships and socioeconomic reforms. In the early 1960s the focus on health shifted from a medical practice model to a preventive practice model (Verderese, 1979). The valuable role of nurses as health promoters (*promotoras de salud*) was also encouraged in the 1970s when the World Health Organization, via the Alma Ata Declaration, suggested a shift from cure to prevention for primary health care services, and nurses began to develop services for the rural population. During the last two decades of the 20th century, however, social transformations led to a drastic reduction in health care expenditures, a change in the distribution of health insurance and delivery, and a different allotment of human resources as determined by market forces.

In general, Latin American health policies have produced more conceptual dichotomies for health workers than solutions, and nursing has been one of the disciplines that in practice has been more heavily influenced by health and educational polices (Infante et. al., 1992). As

Manfredi and Souza (1986) complained, "The individual/collective health, the curative/ preventive services, and [therefore the policies] have promoted the dispersion of resources, inefficient use of technology, lack of harmony among health services, education and research areas, and lack of equity in the distribution of services" (p. 474). Therefore, in the last part of the century, as a consequence of an increasing emphasis on health care reform and private service, professional nurses have faced more complex situations in the attempt to clarify their roles.

Educational Development

In Latin America general education comprises three levels: basic education (eight years), higher education (four years), and university or superior education (from three to six years; Monterrosa, Lange, & Chompre, 1990a). There is a heterogeneous variety of programs in nursing, but for average nursing practice, the programs can be divided into three levels: the assistant nurse (or nurse's aide), with a minimum level of education in high school and one year of learning in a health institution; the technical nurse, with a full high school education and training of one to two years in private/public health or educational institutions; and the university nurse, with a four- or five-year baccalaureate degree from a university and the choice to achieve a nursing specialization diploma or a master's or doctoral degree (Monterrosa et al., 1990a). The specialty programs usually last a year and the postgraduate courses two years and result in a specialist diploma or master's degree (Manfredi & Souza, 1986). Most of the schools offer the baccalaureate in conjunction with the initial basic nursing program. However, after the health reform of the 1990s, nursing curricula have become more flexible and variable (Najera & Castrillón, 2003).

In terms of time availability and preparation of faculty members at the university level, in the 1980s, 62% of the full-time faculty were nursing professors, with 44% of these having a specialization or a master's degree and only 2% a doctoral degree (Monterrosa et al., 1990a). Therefore, qualified nursing professors comprise less than half of the qualified full-time faculty members in nursing programs. It is possible that since 2000 the number of nursing professors

with specialization and degrees has increased, but there is no existing database. The rest of the faculty members come from other fields and include physicians, nutritionists, midwives, and so on. In the earliest 1990s the graduate programs in seven countries of Latin America included 32 specialization diplomas, 16 master's degrees, and four doctoral programs (Wright & Garzón, 1995). Thus education in nursing programs at the university level in Latin America has occurred in a variety of ways, and differences in regional policies have limited advances in the profession across the region as a whole. Today, economic reform and the increase in health care privatization have created new factors that affect the type of practice and the education levels in the nursing profession (Najera & Castrillón, 2003).

The major limitations to graduate programs include the lack of systematic policies guiding the programs, a lack of homogeneous criteria in the preparation of graduate programs, and little clarity in defining the different levels of functions and purposes of the programs (PAHO, 1984). Nevertheless, there has been significant, albeit slow, progress in nursing education including an increase in the number of schools and students, greater numbers of nursing programs incorporated into the universities, a single professional level of nursing education, more academic preparation for rural and community practice, more educational technology used in curricula, more simulation practice in class, and a greater predominance of student participation in teaching strategies used (Ferreira, Collado, & Manfredi, 1989). Today, there is an increasing interest in the nursing discipline at education level (Duran de Villalobos, 2003).

Research Development

Research in graduate programs in nursing in Latin America began developing slowly during the 1970s, and there is still limited experience in nursing science research. Indeed, as Stiepovich, Enriquez, and Clericus (1996) pointed out, "The research development cannot be understood without the political, economic and social context" (p. 42). In other contexts, professional nurses have contributed to research and have served as a significant instrument in

making professional decisions and providing feedback in practice (Gibbons, 1980). Among Latin American countries, however, there exists a diversity of experiences with a variety of results in knowledge production and little impact. Furthermore, nursing researchers have experienced barriers and limitations directly because of the culturally privileged status of men compared to women academics. Barriers to nursing research have been identified as heavy workloads, insufficient nursing human resources, multiple jobs to achieve better salaries, and the lack of a systematic policy for nursing research (Stiepovich et al., 1996). Preparing faculty nurses and students in the field of research was a goal declared in the VII Iberoamerican Nursing Education Conference (*Conferencia Iberoamerica de Educacion en Enfermeria*) in Colombia in 2003 (Romero, 2003). Therefore, there is a need to support more professional nurses and students in entering research roles by stressing the importance of the benefits, particularly as more new graduate programs begin in the region.

Nursing Practice Development

The majority of health personnel in Latin America are nurses, but most of them do not receive adequate nursing preparation. Although professional nurses provide leadership to the various members of the nursing team, in the early 1980s they comprised approximately 20% of the total (Manfredi, 1983). There is limited information on their practice, especially on the number of activities in the private health sector. As Ferreira et al. (1989) noted, after health reform, the policies have focused on problems emanating from practice. But Najera and Castrillón (2003), discussing the work of Lange et al., mentioned that "nursing comprises 50-60% of the total work force in the health care system" (p. 7). In general, nurses have exhibited little interest in the primary health care level of practice, there has been a permanent chronic lack of professional nurses, and there is a need to change the focus of nursing models from the hospital to the community in the public sector. As well, nurses are migrating to the private sector because of the greater access to technological advances and fewer positions in the public sector, which has higher numbers of temporary positions and lower salaries or benefits.

The barriers in nursing practice demonstrate the low level of priority that health, health care workers, and female workers have had. Consequently, nurses do not have sufficient authority with responsibility in their positions, and they perceive a lack of professional identity and recognition for their professional work. Nurses have not critically analyzed new possibilities in the variety of nursing services required (Lange et al., 1991). Professional nurses in Latin America are wedged in a conflict between the ordinary reality of duties and attention to their social responsibilities. Health policies and the forces of the market in health practice are explicitly in opposition: On one hand, health policies focuses on primary health care and educational leadership in communities (Land, 1998), and on the other hand, health practice focuses on high technology and specialization in the hospitals (Cerezo et al., 1979; Manfredi & Souza, 1986). For these reasons, as Scatena Villa et al. (1999) cautioned regarding the Brazilian experience, "transforming nursing practice requires the study of the different forms of nursing in the health system and nurses' place in the labor market" (p. 401). Today, few reports have identified how nurses are coping from a practical viewpoint in the different types of employment, especially in the extensive private sectors; that is, clinics, senior centres, child care centres, and home care.

In summary, professional nursing practice in Latin America involves two broad areas: the traditional public sector positions and the variety of jobs in the private sector. Lange et al. (1991) contended that there are some differences between the public system and the private system, where in the public system

> professional nurses do not have a very different role in practice from that of nurse assistants. But, in some private hospitals, professional nurses are responsible for all the duties in a 24-hour day because they do not give nursing practice duties to the nurses' assistants. (p. 24)

Moreover, Lange et al. concluded that "in the private clinics and university private hospitals, the professional nurses not only do clinical interventions but also have administrative and educational roles, and they have a clearly different role from that of the assistant nurse" (p. 24). The different types of nursing practice are related to the variety of services that the private health sector offers

that focus on the quality of services, cost, and efficiency. Therefore, professional nurses have been vulnerable to changes in the health care system, and little attention has been paid to issues of autonomy, professional identity, and legislative control.

Nursing Associations and Legislation

In Latin America nurses' participation in policymaking in the health and education arena has always been restricted. According to Monterrosa et al. (1990c), professional nurses are a group that rate low on the social scale for the following reasons: (a) Nurses are predominantly female, (b) Latin American nursing students come from the lower social classes, (c) nursing students have poor elementary and high school preparation, and (d) nurses as a group have not been actively involved in social and political movements. From a feminist perspective, nurses in Latin America do not experience lack of prestige because the profession is feminine; rather, the profession is primarily feminine because it lacks prestige (Monterrosa et al., 1990c). For example, in a South American meeting on nursing policies and legislation, Colman (1995) reported that "nurses in Latin American have not participated in making policies about health, neither in making decisions about human resources of nursing personnel, education, practice, development and labor environment. Others decide for us" (p. 8).

Although nurses have not participated directly in the policy-making process, nursing policies do exist in the region. Nursing regulations were established by the national nurses' associations (NNAs) that control the profession's legal aspects. With the support of the International Council of Nursing (ICN) for the NNAs, the associations have provided input into the regulation of nursing practice. Nevertheless, many issues remain uncertain and unresolved because of a lack of legislation suitable for nurses. According to Monterrosa et al. (1990c), the challenges to the future of nursing services lie both within institutions and autonomously. In Latin America the regional association for nurses is the Pan American Federation of Professional Nurses (FEPPEN), created in 1970 with a mission to foster relationships among nursing associations in 20 countries of Latin America whose interest is the promotion of nursing

participation in associations, political parties, and other social organizations (FEPPEN, 2004). Another important organization is the Latin American Association of Nursing Schools and Faculties (ALADEFE), whose interest is the collaboration and development of nursing practice and the promotion and development of nursing education (ALADEFE, 2004). The Iberoamerican Nursing Federation (FIDE), created in 1992 to achieve a more global context, includes Spain and Portugal. With the new global trade relationships, a Regional Commission of Nurses in Mercosur (CREM) was established in 1993 to connect South American countries through a new policy of common trade, education regulations, and legislation concerning labour conditions (Perich, 1995). The growth of new nursing associations in Latin America since the 1970s, with a period of silence in the 1980s but a revitalization in the 1990s, is a signal of the increasing consciousness of nurses on the value of becoming more organized in the region. As Vargas (1995) concluded, "If professional nurses want to influence the health policies of [their] country, they must make a political commitment to strengthen nursing associations, actively participate in society, and raise their own voices to be heard" (p. 65).

Reflections on Nursing Autonomy in Latin America

Nursing in Latin America has been affected by global forces through a variety of heterogeneous programs that have been related to historical and economic processes as well as to professional development processes in the region. As a group, nurses are mainly women who, in a male-dominated society, have suffered from a lack of legal and political decision-making powers of their own. Therefore, the degree of knowledge, the degree of monopoly, the degree of external recognition, and the degree of professional organization have been constrained through different periods of their professional development. They use the same body of knowledge used by nurses internationally, but access to new research findings is sometimes limited. Monterrosa et al. (1990b) advised that issues of autonomy be addressed: "The fulfillment of the norms and regulations for nursing practice as well as education of the different categories of nursing personnel have not been completely solved" (p. 231). A lack of information also exists about the

different places where nurses work, especially in the private sector, and the roles and responsibilities that they assume. Therefore, more understanding of the forces that are affecting nursing autonomy must be generated to enhance the professionalism of nursing in Latin America. This could be accomplished by supporting an increase in degree programs in nursing education, focusing on expanding scopes of practice, adding more nursing governance over legal regulations of their practice, reconsidering the vital importance of more cohesive associations and collective negotiations in a new distribution of health care systems, and fostering a strong political commitment in its members. Nurses may aspire to greater autonomy and credibility through increased leadership roles in health care delivery.

The Chilean Context

Because governments have tried to increase incentives for private sector health insurance and services, many Latin American countries are moving toward a more privatized health care system. The Chilean health system today is a mix of public and private medical care in which one quarter of the population has private insurance. For more than 20 years in a mixed health system, Chilean professional nurses have been part of the women workers who have been affected by the reforms. New professional issues in health reform have raised new problems, and other professional problems remain. Employment in private health institutions leads to a perception of higher prestige, but there is a lack of information on the numbers and roles of nurses working in both sectors. In addition, cultural traditions such as "machismo" in the society and the medical models of health have restrained the development of nursing in a variety of programs. Nursing organizations are continuously struggling to increase their memberships and leadership to bring strength to the profession.

Overview of Chile, the Country

Chile is a long narrow country located in the extreme southwest of South America. It has a continental area of 756,626 square miles; at its widest point it is only 300 miles wide, but it is

2,700 miles long. Its borders are the Andes Mountains and Argentina to the east, the desert and Bolivia and Peru to the north, the Pacific Ocean to the west, and the Antarctic Ocean to the south. Therefore, Chile is geographically isolated, but has a rich variety of climates, lands, and people. Chile had a population in 2001 of approximately 15.4 million (PAHO, 2002), located mainly in urban cities. Geographically, Chile is a country divided into 13 regions, with 51 provinces. Chileans are predominately *mestizos*, a mixture of Spanish and indigenous peoples. The official language is Spanish, but there are some indigenous people in the south who speak Mapudungu and in the north who speak Aymara.

Throughout its early history a variety of indigenous groups inhabited Chile's coasts and valleys. After the arrival of the Spanish conquerors, Chile was controlled by the Spanish Crown in the north-central area and the Mapuche Indians in the south. By 1818 the country was politically independent of Spain and became a Republic in 1925. In the early part of the 20th century, Chile had a well-developed political system based on a democratic government; however, in the middle of the 20th century, social and political issues in South America brought Chile to a serious crisis. After a 1973 military coup, a political dictatorship began that lasted 17 years. The country was led by Augusto Pinochet, who allowed the introduction of economic neoliberal reforms in 1977 that transformed Chile into a low-wage open economy as a result of savage reductions in public spending (Barrientos, 2002). Since 1989 three democratic governments have managed a similar economy, but with more emphasis on social equity and human rights issues (Toloza & Lahera, 2000).

Table 1 provides a comparison of key demographic and epidemiological indicators in Chile and Canada.

Table 1

Comparison of Chilean and Canadian Indicators (2001-2002)

Indicators	Chile	Canada
Economic		
Gross domestic product (GDP) per capita	U$8,410	U$25,440
Variation between 20% highest and 20% lowest	17. 4	5.2
National health expenditure per capita	U$331	U$1,945
Sociodemographic		
Literacy rates	95.5	99.0
Life expectancy	78.4 (F) - 72.4 (M)	82.1 (F) 76.3(M)
Access to purified drinking water	99% (U) - 47% (R)	99.8% (U)
Epidemiological		
Infant mortality rate	10,1 x 1,000	7,1 x 1,000
Maternal mortality rate	17,0 x 100,000	3,8 x 100,000
Physicians	13,0 x 10,000	22,4 x 10,000
Nurses	4,44 x 10,000*	74,6 x 10,000

* Chilean nurses are only those who have a university degree in nursing.
(PAHO, 2002)

Description of the Health Care System

Since the early 1980s the transformation of the health care system in Chile has produced a shift from the state as a benefactor to the state's playing a subsidiary role with an emphasis on productivity and financial management by the private sector. Deep institutional reforms included five important steps: decentralization of the National Health System into regional service areas and regrouping these into the National Health Service system (NHSS), transfer of responsibilities for health care in terms of both infrastructure and personnel for the delivery of primary health care to the municipalities, creation of a financial institution (FONASA) to administer health-sector resources, establishment of new mechanisms to finance hospitals and municipalities' health facilities according to the amount and type of service rendered, and, finally, development of a

legislative framework and financial mechanisms to support prepaid private health insurance plans through ISAPRES (Institutos Salud Previsional Health Insurance Plans; World Bank, 1995).

Basically, the reform consisted of implementing these policies and decreasing health investment in the public health sector. For example, public health spending was reduced and solely focused on target groups and areas of extreme need, thus having negative effects on the quality and coverage of public health services (Azevedo, 1998). At the same time, increasing opportunities for the private sector were incorporated into the health system. As Barrientos and Lloyd-Sherlock (2000) reported, "The main objectives were to expand the role of the private sector in provision and financing, and to improve resource allocation and promote decentralization within the publicly funded sector" (p. 418). For example, private medical care is offered under the free market approach with its emphasis on "both private-sector participation and out-of-pocket payments by consumers" (Scarpaci, 1988, p. 14). After 20 years of health reform, the private health sector "covers just under a quarter of population, but their membership is predominantly from high-income groups, with low health risks" (Barrientos, 2002, p. 445).

More than 20 years after the reform, the Chilean health sector is now characterized by a combination of public and private providers. The public health system has been decentralized into 29 health services areas. Outpatient care—government health clinics and primary health care centres—has been transferred to the municipalities, which are in charge of management. Consequently, public health delivery is covered under the domain of the Ministry of Health (MOH) through the coordination of the Sub-Secretary of Health, which supervises the operations of the National Health Care Service System (NHSS) and four agencies: the National Health Fund (FONASA), the Central Supply Facility-Warehouse (CENABAST), the Institute of Public Health (ISP), and the Superintendence of ISAPRES.

The NHSS, through its 29 regional services (HS), delivers curative and preventive services in 29 geographically defined health service areas and covers approximately 61% of the population (PAHO, 2000). The NHSS is responsible for formulating policies, defining national

norms and standards, and planning and monitoring the 29 HSs, which have some autonomy across the country and are responsible for the operation of all public hospitals in their geographical areas including technical control of the primary care system that is managed by each municipality.

FONASA administers and distributes the financial resources of the NHSS through central government allocations for health and the 7% payroll deduction earmarked for health from active workers as well as pensioned salaried workers. Another program offered by FONASA is the Preferred Providers System (PPS), which is a collaborative initiative between workers' contributions and those of FONASA. The National Health Fund pays only a portion of the cost of the required ambulatory and inpatient services, and the user pays the other part with a voucher purchased from FONASA. Providers such as physicians, nurses, laboratories, and clinics redeem the vouchers for 100% of a pre-agreed price. The NHSS has four revenue sources administered by FONASA: transfers from a 7% payroll deduction (40% of its revenues), the central government's contribution, sales of vouchers to FONASA for selective services in PPS (7% of revenues), and fees from the sale of services in public facilities (World Bank, 1995).

The Central Supplies Facility (CENABAST) is an institution that purchases drugs and other supplies for medical uses, and the Institute of Public Health (ISP) is the national reference laboratory that controls the quality of drugs and other products. Finally, the Superintendency of ISAPRES, created in 1990, is the final authority, and it regulates the private health sector through audits of the legal and financial aspects of these health institutions. As Kifmann (1998) explained, "This checks that insurance policies conform to statutory requirements, acts as an ombudsman in conflict between ISAPRES and their members and can also issue general regulations to improve the contractual regulations between these two" (p. 142).

As a result of the co-existence of two types of health providers, public and private, Chile has experienced a new and different distribution of insurance, resources, and health services, which has resulted in a lack of equity in health care (Martin, 2000). First, there is a correlation

between higher levels of financial income and private insurance coverage (Scarpaci, 1989). Second, the resources spent in the public and private sector are a little different; for example, the difference in dollars per capita allocated between both systems in 1995 showed that the private sector spent US$235 and the public sector US$116 (PAHO, 2000). Third, there are some differences in the delivery of services. In 1995 the public sector had 3.5 beds per 1,000 individuals, whereas the private sector had 3.0 beds per 1,000 individuals; and in the public sector the average length of stay in hospitals was 7-8 days, but in the private sector the average was 4-5 days (Azevedo, 1998). Fourth, human resources have also been affected in the allocation of health personnel because of incentives from the private health sector to attract qualified staff.

After more than 10 years of democratic governments and positive health indicators, there is a need for reform of the mixed health system to create a system in which public and private sectors can compete with and complement each other. The important issue is not only improving equity in financing and delivery of health care, but also creating efficiency in public spending on health care (Bitran et al., 2000). More specifically, Martin (2000) suggested, Chile must address issues such as "the state's role in financing; the relationship between resources, efficiency, and equity; human resources policies; competitiveness in health care; decentralisation; and greater administrative autonomy" (p. 331). Barrientos (2002), in discussing the Presidential Address of 2001, noted:

> The creation of a solidarity fund to cover the costs of providing health care to the uninsured and the poor is most important. It is proposed that it is financed from tax revenues and a fraction of health payroll contributions from both FONASA and ISAPRE affiliates. (p. 452)

New health reform legislation that has been debated in Parliament since 1993 and is designed to improve the quality of the health care system was finally approved by law #19.937 in January 2004 (Ministerio de Salud de Chile [MINSAL], 2004).

The Nursing Profession in Chile

Professional nursing in Chile has its roots in an historical period of improvement in the whole education system from 1940 to the 1970s. After 1973, however, nursing growth slowed because of the political crisis in Chile, which was followed by economic crisis and reform in the 1980s. Since the 1990s the globalized economy has brought a mixture of improvement in the access to a variety of jobs and opportunities in nursing and confusion regarding professional autonomy and control over the profession. The nursing profession, as a primarily female occupation, has been dealing with gender and job inequalities throughout its history. Cultural aspects of Chilean male domination in the workplace make some positions less available for women. As well, privatization of health care in Chile has raised new issues for professional nursing that are deeply rooted not only in the economic and political contexts, but also in the cultural and professional nursing contexts (Corral, 2003).

Gender Context

Professional nurses comprise part of the 50.6% of Chile's population who are women (Stiepovic, 1998). The level of education for women has improved substantially throughout the last century. Despite their higher level of education, however, there is still no gender equality. Men with similar levels of education still have better employment opportunities and higher salaries. Women now have more access to university degrees, but experience a difference in their opportunities and decisions to study (Silva, 1996). In general, jobs available to women are strongly focused on the traditional female role and offer lower salaries. Women are commonly employed in domestic services and personal services; that is, secretaries, saleswomen, and health care workers (Valdes, 2000). In term of professional occupations, Valdes contended, "Women seek professional training in specialities that are an extension of their traditional roles: social service, teaching, nursing, preschool education, etc." (p. 460).

Even though higher education for women has produced more opportunities for them to make their own decisions, independent women often find themselves in conflict with conservative religious traditions and social customs in Chilean society. The conservative right-wing movement, supported by the entrepreneurial business class and the Roman Catholic Church, has an influence on cultural issues via the media (Cortes, 2000; Parker, 2000). In these chauvinist traditions, the roles of women as mothers and wives are valued, whereas a woman's right to self-determination is devalued (Allende, 2002). Some government policies, through the influence of the SERNAM (national governmental office for women) and some NGOs (nongovernmental organizations), have supported equality for women, but a great deal of work must still be done.

Historical Background of the Nursing Profession

In the last part of the 19th century, social and political influences from Europe to Chile fostered the development of nursing to assist medical practice. In Chile the first school of nursing opened in 1902, and by 1906 the government passed a law that created the State Nursing School at the University of Chile, which allowed nursing to be taught exclusively in university centres. The first Sanitary Nursing Program, focusing on public health nursing, was established in 1926 (Flores, 1965). In the 1950s and 1960s more university programs were created, and by 1973 Chile had 13 schools of nursing. After the economic and educational reform of the 1980s, however, some nursing schools were closed as part of the educational reform in universities imposed by the military government. With Chile's democratization in the 1990s, new public and private nursing schools have opened to increase the output of qualified nurses. However, the accelerated tendency to open schools of nursing in the private sector is viewed with caution and concern ("*Carreras de enfermería en vías de saturación*," 2003).

Even in Chile, where professional nursing programs have been offered only in universities, the development of nursing knowledge and research has been limited. After the 1970s the political and social crisis reduced the number of nursing professors. Some left the country or left nursing education. Later, in the 1980s, health and educational reforms limited

resources for the production of scientific research because of a period of fiscal restraint that limited the creation of new faculty positions. Even though there were improvements in the last decade of the 20th century, there are still few faculty members who conduct nursing research and perceive a responsibility for generating nursing knowledge. A lack of institutional policies and funding limits the production of research in the field, and faculty members have limited research experience, inadequate access to literature, and few opportunities for publication (Lange & Campos, 1997).

Higher education in Chile today has three levels of preparation in two sectors—the public and the private. The university level is made up of traditional public universities that receive direct funding from the state, as well as private universities. The other two levels, the professional and vocational institutes, both actively increased the number of programs after the educational reforms of the 1980s, but this occurred mainly in recent years in the private sector (Atria, 2000). Until the 1980s the educational system in nursing offered two levels of nursing preparation: the nursing assistant, which requires 1,500 hours of preparation in a public hospital to obtain a diploma; and the registered nurse, a four- to five-year program of studies at Chilean universities to obtain a professional title. Since the 1990s Chilean universities have offered the title of professional nurse plus the bachelor's degree in nursing. Today, after the health care and educational reforms of the 1980s, there are two additional levels: the technician program, which requires 1,600 to 1,800 hours of training in private professional institutes; and the nurse's aide program, which, with one year of basic nursing, trains nurses' aides for a variety of positions, especially in private home care or senior care facilities.

There has been an increasing demand for professional nurses in the different health care institutions and settings because professional nurses are managing a variety of services with different levels of nursing staff. However, as Flores and Weintraub (1998) found in a comparison of public and private health institutions, nurses working in hospitals or clinics in the private sector have clear role definitions in terms of providing full/complete care to their patients (i.e., a ratio of

1 nurse to 1 bed). In contrast, nurses working in the public sector tend to delegate duties to other personnel and have less contact with patients and more management duties (i.e., a ratio of 1 nurse to 10 beds). Both sectors are similar in a comparison of nurses' perceptions of salary, professional development opportunities, and work schedules. In the private health sector there is a high interest in professional nurses because they are "symbols of quality in the image of the institution" (p. 63).

Professionalism Among Chilean Nurses

Professional nurses in Chile have gone through a process similar to that in other countries in Latin America in terms of economic and political transformations. The Chilean process during the last 30 years—from a dictatorship to democratic governments—has had an impact on all of Chilean society. From its origins to the present time, the nursing profession has been involved and affected, according to Alarcón, Astudillo, Barrios, and Rivas (2002):

> Profound reforms in the economic and social context of the health system have affected the role of nurses within the health care delivery system. Some of the transformations have been the continuous privatization of the Chilean national health system, the proliferation of private health organization, and the technical dependency on healthcare. (p. 336)

Because Chile has seen a chronic lack of professional nurses since the 1960s (Castillo, 1997), with the most serious shortage during the health reforms of the 1980s, there have been barriers to the development of the nursing profession. During the 1980s the dismissal of nurses working in the public sector caused their exile and migration to the private health sector, which began to open new clinics and hospitals. Meanwhile, at higher educational levels, educational reforms caused further migration of nursing faculty members to other activities. This led to a reduction in the number of graduate nurses as a consequence of the closing of nursing schools (Hernandez & Weintraub, 1998). Moreover, the lack of departments of nursing and the lack of professional organization control over nursing were significant. During the 1990s the number of graduates slowly began to rise with the opening of new schools in public and private universities.

According to Castillo (1997), however, "[Today] there are twelve nursing schools with 287 graduates a year, equivalent to only 52% of the ratio of the 1970s" (p. 8). During the middle 1990s the Ministry of Health amended its human resources policies to hire more professional nurses, raising the number in 1999 to 3,509 (MINSAL, 1999). The availability of professional nurses, however, is still low, with 44.6 per 100,000 inhabitants (Hernandez & Weintraub, 1998). If we compare this ratio with Canada, in 1995 Canada had 78.66 nurses per 10,000 inhabitants (PAHO, 2001), whereas in Chile there were only 4.2 nurses per 10,000 inhabitants in the public sector in 1997 (Castillo, 1997). This lack of nurses has more of an impact in rural than in urban areas, and in the public than in the private sector.

In this new millennium Chilean professional nurses must make use of existing advantages to promote more professional development. In this process professional nurses have found barriers to achievement in many of the criteria for classification as professionals based on Turner and Hodge's (1970) elements of occupations. In the following discussion the degree of substantive theory and technique, monopoly, social recognition, and organization is considered.

Degree of Substantive Theory and Technique

For a long period of time during the 20th century government policy considered education a vital element in improving the social conditions of the population. Therefore, many nurses were faculty members with the prestige and autonomy needed to develop programs in nursing, particularly with a focus on primary health care. In 1981 the government introduced legislation that focused "primarily on opening higher education to private sector initiatives, introducing an environment that, supporters maintained, would foster academic excellence through competition" (Atria, 2000, p. 596). In addition, legislation mandated that only 10 programs designed as baccalaureate degrees were to be offered exclusively at the university level. Nursing was not included because existing programs did not offer baccalaureate degrees. Therefore, good opportunities surfaced for the introduction of certificate nursing programs in the private sector. Nevertheless, in the mid 1980s a strong nursing association with a cohesive political commitment

ensured that nursing programs remained only in universities and that baccalaureate degrees were offered.

Until the 1990s there was little interest from Chilean institutions and the public in developing new graduate nursing degree programs (master's and doctoral) because of the low status of nurses and women. Nursing has been viewed as a women's profession, with little relationship to autonomous knowledge and research at the university level (Yañez & Araya, 1999). The paternalistic vision of medical and nursing careers has created barriers to accessing more information for nurses because of the different orientations of the two professions, and universities and local authorities have not been clearly supportive in providing the time or financial resources for nurses to do research or implement graduate programs. For example, in the context of research and publication, Lange and Campos (1997) explained, "In fact, nursing research is considered a luxury in Chile. It is still not part of the nurse's role in any health institutions and not in most universities" (p. 23).

It is clear that the development of professional nursing in Chile has been limited by the chronic shortage of nurses with advanced levels of education, such as master's and doctoral degrees. Lange and Ailinger (2001) reported, "In Chile, where nursing is a profession that is taught exclusively at the baccalaureate level in universities, there is one master's degree program in nursing" (p. 109). Few nurses have attained graduate degrees, and most of the master's prepared nurses have earned their degrees in public health or education rather than in nursing (Lange & Campos, 1997). Thus, few faculty members are qualified to teach advanced courses in nursing. For nursing knowledge and nursing science to advance in Chile, strategies are required to attract professional nurses to graduate programs in nursing.

In 2003 there were 24 nursing schools, 11 of which were private nursing schools, that offered 32 nursing undergraduate programs with five-year baccalaureate degrees ("*Carreras de enfermería en vías de saturación*," 2003); two master's programs (one public and one private); and a new doctoral program implemented at the University of Concepción (Paravic &

Valenzuela, 2003). A specialization diploma is offered only at the university level in four Chilean universities; the program includes one nursing-expertise field and research applied to practice (Jofre, 2003). Therefore, there are signs that more opportunities for nursing at the university level are being created.

Degree of Monopoly

Through educational programs in Chile, professional nurses have to make greater efforts to increase their monopoly over professional activities. The quality of the curriculum must be improved through developing standards and a program of accreditation. The Chilean Nursing Education Association (CHNEA), although it acts as the advisory board for curriculum development, has been unable to develop effective leadership and provide sufficient authority to control different new programs because universities have autonomy to create and develop nursing programs (*Ejercicio Profesional*, 2003). Consequently, new nursing curricula are sometimes treated sceptically by authorities in the university system, who sometimes make decisions based on market demands rather than on consultation with leaders and members of the nurses' professional organizations ("*Carreras de enfermería en vías de saturacion*," 2003).

Over the last 10 years the quality of bachelor's degree programs in nursing has not been adequately evaluated because of a lack of accreditation programs in nursing education. The CHNEA has produced a document on the accreditation of baccalaureate nursing programs with criteria and minimum standards (CHNEA, 2002). Moreover, with a lack of legislation requiring registration to practice professional nursing, Chilean nurses have no formal mechanisms through which their knowledge and skills may be tested or through which professional standards to protect the public may be developed and implemented. Graduation from a university nursing program is required to work as a professional nurse, but there is no mechanism through which this privilege may be revoked. As a result, nurses who have been working in the private health sector may receive performance evaluations that will have an impact on their positions, careers, time of working, salaries, resources, and so on; but this depends on the policies within each

institution. In the public health sector, however, nursing roles are delineated for all levels of practice (e.g., staff nurses, head nurses, managers). This may mean that nursing in the public sector is more inflexible than nursing in the private sector and that opportunities for adapting roles to emerging practice needs are more limited in the public sector. These possible differences are more fully explored in chapters 6 and 7. With respect to salaries and benefits in the two systems, public and private, they offer similar salaries, professional development opportunities, and work schedules (Hernandez & Weintraub, 1998).

Specialization diploma programs in nursing, with their reliance on expertise, are more attractive to nurses, especially programs involving the management of nursing service in hospitals. Thus, there is an extended list of courses and certificate diplomas offered rather than graduate programs (*Capacitación, Colegio de Enfermeras de Chile [AG]*, 2004). However, few opportunities and positions are available for nurses who receive a specialization diploma in a clinical area of nursing to command better salaries, higher positions, and more recognition. In summary, accreditation of nursing programs and licensure/credentialing to practice, which professional nurses in Chile should pursue to meet the criteria for true professional status, are important to establish more control over practice and education.

Degree of External Recognition

As seen in the number of new nursing schools today, there is a greater demand for professional nursing programs and nurses in practice; however, it is not clear whether the demand for professional nurses is related more to the professional prestige of the new private sector services or the desire for quality nursing services. The newly emergent private health sector has increased the number and variety of care facilities such as clinics, hospitals, occupational services, home care, senior services, and emergency units. The value of the private sector in the mixed health care system has been systematically introduced into the consciousness of Chilean society, and new applicants have been attracted by the quality and prestige of professions, including nursing programs, in the private system. Therefore, nursing students and new graduate

nurses gravitate toward the private sector because of the perception that it offers more technological advances and benefits. Professional nurses also have a better perception of the private sector (Hernandez & Weintraub, 1998). In terms of decisions concerning job preferences, professional nurses have a more positive perception of the state of the private health sector than they do of the public health sector (Hernandez & Weintraub, 1998). Hernandez and Weintraub, however, noted similarities in the working conditions and salaries of nurses.

Leadership in nursing has been affected and limited by external forces related to health care reform, which has resulted in competition for leadership roles in health care. Opportunities for nursing leadership roles in the decision-making process in health organizations have decreased. Alarcón et al. (2002) pointed out, "Business managers for instance, make decisions on behalf of nurses. Thus, one of the critical changes in nursing leadership has been the loss of autonomy to make decisions" (p. 339). The lack of nursing departments or offices in hospitals has dispersed cohesion in the nursing group.

With few nursing leaders, the image of nurses as subordinate to physicians has continued. This may be related to insufficient political involvement and the stereotypes perpetuated in media reports (Yañez & Araya, 1999). The invisibility of nurses as a professional group with scientific knowledge and unique roles has been maintained by the media and public opinion, which more often portray nurses as attractive medical assistants rather than as women utilizing their knowledge in their own domain (Yañez & Araya, 1999). The Chilean Nurses' Association (CHNC) has been fairly successful in gaining access to the media to foster a more positive influence on public perceptions. Efforts have been initiated to reinforce nurses' professional identities, such as the creation of the Nursing Student Association, NSA (*"Primer encuentro nacional de estudiantes de enfermería,"* 2001). Some faculty members and nursing managers have begun to introduce measures to motivate the participation of students and new graduates in professional endeavours and civil society. Nurses in practice are perceived to have a lack of information on and knowledge of social context and relevance, but Martinez, Diaz, Guzman, and

Arazo (2001) argued that nurses in practice have access to information that could raise the awareness of new nursing structures, the implications of the Sanitary Code Law, and new opportunities in FONASA; however, "in general, [nurses] have a low level of information about these issues" (p. 7).

Degree of Organization

The CHNC was founded in 1952 as a corporation under Public Law for the purpose of "heading the development of nursing in Chile, supervising the professional service of nursing and qualifying nurses" (Flores, 1965, p. 15). The structural organization of the CHNC included a general board and departments, and issues relating to working conditions, education, publication, and public and community boards were emphasized ("*Rol de la Enfermera*," 1972). Membership was compulsory for all nurses, and a committee analyzed ethical responsibilities. The CHNC explicitly defined the role of nurses in Chilean society, controlled the practice of the profession, and attained membership in the International Council of Nurses (ICN) in 1954. However, in 1979 it was forced to relinquish its control over the regulation of nursing practice as well as control over its members, which continues today. Chilean law #3.621 abolished the CHNC as a public corporation; thus it became a private corporation with a limited mandate for control over professional issues such as licensure to practice as a professional nurse (*Colegio de Enfermeras de Chile [AG]*, 1981). The Chilean Nurses' Association has a code of ethics, but, because membership is voluntary, it is scarcely used by professional nurses because few choose to become members (Westerman, 1999).

Since the 1990s a slow recovery of the CHNC as a professional group has occurred, with the inclusion of more members and the political commitment to work toward the betterment of the profession. Positive results have been realized on some issues. For example, through negotiation with National Congress health authorities, professional nurses were defined in 1997 as an autonomous profession through the Chilean Sanitary Code, which regulates the health profession in Chile (Castillo, 1999). With this new law it is assumed that clarifying the scope of

their nursing practice will give professional nurses more autonomy. Chilean nurses can now be held legally responsible for their nursing actions and can set up autonomous practices separate from physicians and health care institutions. Therefore, professional nurses may have a clearer understanding not only of their responsibility for their own knowledge and skills, but also of the legal penalties in cases of professional incompetence. Moreover, at a National Conference of Nurses in 2001, the CHNC tried to raise awareness of the process of autonomy in nursing by developing strategies to make nurses aware of the importance and effects of recognition through the Sanitary Code Law, to apprise them of issues of power related to leadership and the decision-making arena, and to devise an operational meaning of autonomy in the structure of nursing in each institution ("*XIV Congreso Nacional*," 2001).

Professional nurses, through their nursing organizations, have failed to achieve recognition of their political voice in health care. For example, according to Franceschet (2000), "The [Chilean] context is marked by two main features: a democratizing and neo-liberal state; and a gender ideology that views the social roles surrounding maternity as the most highly valued aspects of women's identity" (p. 6). Nurses have often been linked with the image of physicians' assistants, but physicians in Chile have formed a powerful association with strong political influence. Therefore, professional nurses and the CHNC have had little influence on the health policies of three successive governments that have maintained a biomedical perspective of the health care system. The CHNC has made advances in improving the status, salaries, work protection, and benefits of its members; however, it did not achieve these results without a tenacious agenda throughout years of negotiation by various committees, councils, assemblies, and meetings. The balance is still uncertain, with some success and some failures. For example, one success has been the unified strategy in negotiations between the Ministry of Health and Municipalities, and the CHNC in conjunction with other partners, including nursing assistants, midwives, physiotherapists, and technicians (Corral, 1995) The CHNC, however, has been unable to defend and protect professional nurses in the private sector. Because its membership is low in

the private sector, it lacks the authority and recognition to negotiate with each private institution. With a lack of control over its affiliates and insufficient support from government in the labour agenda, according to Talloni (1989), ex-president of the CHNC:

> the nursing professional is situated in a weak position in both the public and the private sector. There is a deficiency in the labor laws, and a lack of information on the part of professionals about their rights and responsibilities. (p. 24)

The CHNC therefore has been lobbying for mandatory registration of qualified professional nurses and has provided legal information to nurses, especially those who have jobs in the private health sector (Corral, 2003). Thus lobbying for mandatory licensure or registration to practice as a professional nurse is a current priority of the CHNC. Currently, nurses have a choice as to whether or not to register with the professional association. As well, the CHNC, through reformulated policies, is attempting to increase its membership as an imperative for developing and maintaining the cohesiveness of the profession ("*XIV Congreso Nacional*," 2001).

Among its own members the CHNC has also encountered obstacles, such as a lack of incentives to promote affiliation, mechanisms to capture and retain new members, and publicity to create a positive image of nursing. New graduates have easy access to information concerning opportunities for jobs in the private sector. They tend to work for private organizations and have little understanding of the labour laws and their professional responsibilities. What concerns Westerman (1999) the most with regard to the low number of CHNC members is that "a third of them [the nurses] were unable to explain the general purposes of being affiliated with the Nursing Association" (p. 71).

Reflections on Professionalism in the Context of Nursing in Chile

The combination of historical, political, economic, and cultural contexts has greatly influenced the development of professional nursing in Chile. Progress to date can be seen as involving three stages: rich development and progress from professional nursing's origins in the early 1900s to 1973, a paralyzing and confusing period that halted nursing development during

the reforms of the late 1970s and the 1980s, and moderate changes in nursing practice and education in the competitive health system of the neoliberal state beginning in the 1990s.

Professional nurses in this era of social transformation must be concerned with the impact and implications of expanded possibilities for nursing practice, including related needs for change in nursing legislation, education, and research. As well, leadership and strengthening of nursing organizations are needed to foster the cohesiveness of nurses as a group with control over the profession because, as Alarcón et al. (2002) stated, "Nurses have gradually lost the status of leadership that they had in the past and are not creating new knowledge as a way of supporting their practices" (p. 339). Because of the chronic shortage of nurses, the small number of degree programs, and the slow development of cohesive nursing organizations, professional nurses must rethink the meaning of autonomy and professionalism under the new law with its inclusion of an independent role for nurses. New educational markets at the university level in Chile, including in nursing programs, have raised issues related to accreditation and educational standards.

There have been some positive steps. Increased autonomy, more degree programs, more nurses in political action, and emergent standards of nursing practice and education, albeit with a lack of empowerment within their organizations, mean that professional nurses may be developing the support structures and skills that will help to generate a more active transformation into a more autonomous profession. However, they continue to face threats created by the external forces.

With few leaders positioned to influence policies and political agendas, nurses still lack a voice in arenas where important decisions are made.

Reflections on the Overall Review of the Literature

As we move into the 21st century, the combination of a mixed health care system and the high proportion of women's work in the health care system have produced complex challenges for the nursing profession in Chile. The promotion of market competition in health care for the

privately insured population has also been consistent with the dominant economic policies of the region. In this new relationship of supply and demand, nurses, specifically professional nurses, seem to be more attracted to the private health sector, where positions are associated more with status and prestige. This may be detrimental to the development of a strong and autonomous profession.

This research initiative was an attempt to critically analyze nursing as a profession in the Chilean context and to identify social forces that affect the development of nursing practice, education, and research. The criteria of a profession, as identified by Turner and Hodge (1970), have been used to structure the research. Areas explored therefore relate to the development of substantive knowledge and technique, the extent of monopoly over the profession, the degree of external recognition, and the development of professional organizations. Are professional nurses part of the struggle of the group of oppressed women workers who have been directly affected by the globalization of the health market? Is the Chilean mixed health context a setting where the scope of practice is well defined and conducive to the development of a professional identity? Issues of gender, language, and power relationships were explored in an attempt to answer the research questions.

CHAPTER 5:

THE RESEARCH PROCESS

Qualitative research provides an understanding of situations in their uniqueness as part of a particular context and the interactions therein (Patton, 1980). Therefore, the qualitative research approach—with the purpose of answering the research questions and using the researcher as the primary instrument for data collection and analysis, the natural setting of institutions as the fieldwork, the participants' perspectives as the emic insider's view, and an inductive research strategy to develop theorization—is the best approach in order to gain an in-depth understanding of the situation and meaning for those involved. Qualitative research helps in understanding and explaining the meaning of social phenomena with little disruption of the natural setting. According to Merriam (1998), a qualitative case study is "an intensive, holistic description and analysis of a single instance, phenomenon, or social unit" (p. 27).

I conducted a qualitative case study of professional nursing in Chile in health and educational institutions that employ nurses. In this research design the case is an analysis of nursing as a profession in the Chilean context. Chilean professional nurses articulated how they perceived their professional identities and responsibilities in mixed private-public health care and educational systems.

Case Study Research

According to Feagin, Orum, and Sjoberg (1991), a case study is "an in-depth multifaceted investigation, using qualitative research methods, of a single social phenomenon" (p. 2). Yin (1994) explained that the use of case studies involves "contemporary events within a real life context, especially when the boundaries between phenomenon and context are not clearly evident" (p. 13). With the assumption that a case study is both a process of inquiry about the case and the product of that inquiry, "a case study researcher looks for the systematic connections

among the observable behaviors, speculations, causes and treatments" (Stake, 1995, p. 255). Thus, the purpose of the case study is twofold: "On the one hand, it attempts to arrive at a comprehensive understanding of the groups under study: who are its members? . . . At the same time, the case study also attempts to develop more general theoretical statements about regularities in social structure and process" (Becker, 1968, p. 233).

In particular, a case study must focus attention on "the case" and its idiosyncrasies in order to understand its complexity. Stake (1995) asserted that "the case study tells a story about a bounded system, emphasizing the unity and wholeness of that system, but confining the attention to those aspects that are relevant to the research problem at the time" (p. 258). In this study the case study approach was the research method, and professional nursing in Chile was considered the case with a "bounded system." In terms of a qualitative case study design, the heuristic case study illuminates the readers' understanding of the phenomenon of the study. Merriam (1998) added that the researcher, in using the heuristic quality of a case study, for example, "explains the reasons for a problem, the background of a situation, what happened, and why" (p. 31).

Methodologically, Adelman, Kemmis, and Jenkins (1979) described a case study as "eclectic, but its techniques and procedures in common include observation (participant and non-participant), interviews (conducted with varying degrees of structures), audio-visual recording, field note-taking, document collection, and the negotiation of products" (p. 49). First, the selection of a case study approach generally occurs when the researcher is looking for rich, deep data that allow for the development of a solid empirical basis for specific concepts, which may have generalizations. Second, everyday circumstances offer a researcher empirical and theoretical advantages in understanding larger social complexes of actors, actions, and motives. In the case of an organization, such a study allows researchers to become aware of how people act in the organization (e.g., a hospital) and how daily routines influence their work (e.g., nursing practice). Third, the advantage of the case study is that it permits researchers to discover complex sets of decisions and to recount the effects of decisions over time, such as in the case of power and its

influences in different contexts. Fourth, a case study permits the uncovering of the historical dimension of a social phenomenon or setting. And finally, case studies are an important source of new ideas and theories (Feagin et al., 1991).

In terms of context and situation, the case study is a complex entity operating within a number of contexts, including physical, political, economic, ethical, and aesthetic. A case study also has a conceptual structure, usually organized around a small number of research questions. In emphasizing the unit of analysis—the bounded system—"the case" can involve not only a person or enterprise, but also whatever bounded system is of interest, such as an institution, a program, or a population (Stake, 1980). From a case inductive perspective, researchers describe patterns and themes within complex problematic relationships. What researchers learn from a particular case can help reveal how the case is like and unlike other cases (i.e., comparisons of cases). Miles and Huberman (1994) stated:

> By looking at a range of similar and contrasting cases, we can understand a single-case finding, grounding it by specifying how and where and, if possible, why it carries on as it does. We can strengthen the precision, the validity, and the stability of the findings. (p. 29)

The knowledge is then transferred from the researcher to the reader in a framework using crafted structures, thought, conversation, and writing that expands phrases into paragraphs and appends labels onto constructs. In general, the case study has the advantage that "the researchers . . . can deal with the reality behind appearances, with contradictions and the dialectical nature of social life, as well as with a whole that is more than the sum of the parts" (Feagin et al., 1991, p. 39). Thus, a case study design offers a means of investigating complex social units consisting of multiple variables of potential importance in understanding the phenomenon. Because it is anchored in real-life situations, the case study results in a "rich and holistic account of a phenomenon" (Merriam, 1998, p. 41).

Specific Research Approach

In this research study the focus was on how nurses in Chile articulate their understanding of professional nursing and how the context, private or public, in which they work has influenced their professional relationships, roles, responsibilities, and identities. It was determined that ethnical variations would not be included as my focus was on nursing and nurses in general. I explored the problem in relation to the overall structure of professional nursing in Chile and collected data from nursing students and from nurses engaged in practice, education, and administration. As well, I conducted interviews with nurses in leadership positions in nursing associations and the Ministry of Health. In this research study the orientation of the case study was an heuristic comparative qualitative case study (Feagin et al., 1991; Merriam, 1998) that was based on a comparison of the perspectives of professional nurses—the case with a bounded system—and involved the analysis of their articulation of everyday nursing practice (professionalism in nurses), the historical events and processes (development of nursing and nursing organizations in Chile), and organizational patterns to describe social institutions (private and public institutions). I collected data from three geographically different cities (Central, North, and South) to ascertain whether regional differences were as significant as public and private differences when the data were analyzed. As well, I analyzed the findings according to recognized criteria for the assessment of professions and the theoretical perspectives described in the review of literature.

To more clearly outline the research design, the ways in which specific research questions were addressed are described. The specific research questions were:

1. How do professional nurses in Chile
    - choose their place of employment?
    - describe their practice?
    - describe what being a professional nurse means to them?

2. What do professional nurses in Chile

- envision as the ideal future for professional nurses in Chile?
- perceive as changes needed to achieve their desired future?

3. How closely do Chilean professional nurses' descriptions of their practice and their professional identity fit with the criteria of nursing as a profession?

4. How do Chilean nursing students and nursing professors articulate to what extent nursing is a profession in Chile?

5. How does context, in terms of public or private health care or educational institution, influence patterns of responses provided by nurses participating in the research?

I addressed these questions in a variety of ways. To answer question 1 and to partially address question 2, I interviewed nursing staff and managers in hospitals and asked them to describe their practice and their thoughts on professional nursing in Chile. Urban hospitals, those with a high level of complexity of service and classified as type A hospitals, were chosen as the settings from which participants were recruited. These institutions play an important role in professional nursing with regard to who is practicing and managing in these institutions. They reflect also the areas in which the main impact of health reform has been felt most strongly ("*Preparando el XII Congreso*," 1995). Moreover, in consideration of the geographical distribution in each sector, three public and three private health care type A institutions were selected. I selected one public and one private hospital in each of three cities chosen for the study, including Santiago (the capital) and one northern and one southern city.

To answer question 4 and to partially address question 2, I requested access to faculty members and students at universities where professional nurses obtain baccalaureate degrees in Chile and approached five universities, three public and two private, regarding participation in the study. With regard to the private universities, one geographical location lacks a nursing program. In the public universities, two geographical locations have only one public university each, and

one geographical location has three public universities; the first to respond was selected. Students and faculty members were asked to respond in writing to an open-ended questionnaire.

As well, I approached nurses from the Ministry of Health, the Chilean Nurses' Association (CHNC), and the Chilean Nursing Education Association (CHNEA) for interviews. Their perspectives as leaders in the profession provided additional data for question 2.

Research questions 3 and 5 were addressed through the analysis and synthesis of interview and questionnaire data. After analysis, I compared the findings with those in the literature.

Sampling Procedures

This study required the cooperation of Chilean health and educational institutions in both the public and private systems in which professional nurses are working. I sought access through personal appointments with those in authority, because letters requesting access were likely to receive no response in Chile. For this reason, I asked the authorizing person to sign a document granting permission (Appendix A). Therefore, nurses and nursing students participating in this research came from four settings: hospitals, nursing associations, the Ministry of Health, and universities. Details of the numbers and access are described next.

The Hospital Setting

Hospitals in Chile are identified by three levels of complexity and by type of institution. There was no information about the total population of nurses in each institution, but all of the institutions included in the study are type A and have three levels of structural organization in nursing: manager, head nurses, and nursing staff. For this reason, in the hospital setting I sought a nonprobabilistic sample, such as in purposeful sampling, which is based on the assumption that the investigator wants to discover, understand, and gain insights, rather than to generalize results (Patton, 1990). Good potential participants are those who have knowledge of the phenomena. Convenience sampling was used with consideration of certain factors such as time, money,

location, and availability of nurses. In this research, after obtaining agreement from the institutions to participate, I attempted to recruit the highest ranking nurse in the institution, one head nurse, and five staff nurses in each of the six hospitals. I invited all nurses to participate, and generally selected the first to volunteer. I identified the highest ranking nurse and approached her directly. On all nursing units I posted advertisements that invited staff nurses to participate (Appendix B) and sent notices to head nurses inviting their participation (Appendix B). I discussed the planning process for interviews with nurse managers, who then sent me to the nursing units, where I met with the head nurses. After the initial contact, we agreed upon the time and place of the interviews. Criteria for the participation of staff nurses included graduation from a Chilean nursing program and a minimum of two years of nursing practice experience. Nurses from six type A hospitals that were selected according to geographical location—two in the North, two in the South, and two in the Centre, with a total of 30 staff nurses, 6 head nurses, and 6 nurse managers—comprised the total sample of 42 nurses working in the hospital settings.

Nursing Leaders

Nurses working in the Ministry of Health, in the Chilean Nurses' Association, and in the Chilean Association of Nursing Education were also selected. In each of the institutions I expected that a "high-level nurse" would participate. Therefore, I approached the presidents (or the vice presidents) of the Chilean Nurses Association in the three regions and the Chilean Nursing Education Association. As well, I invited the highest ranking nurses in the Ministry of Health to participate, and because no nursing structure exists in the organization, I selected the nurses according to their status with respect to political decision making and health program planning participation. However, between March and April the Ministry of Health was reorganized, which required rescheduling the interviews. A total of seven nurse leaders participated: the national president of the Chilean Nurses' Association, the two regional presidents of the Nursing Association from the North and South, the president of the Chilean Nursing Education Association, the vice-president of the South region of ALADEFE, and two

representatives of the Ministry of Health. I initially made these contacts by telephone and requested a follow-up appointment to confirm the place and time.

The Educational Setting

In 2002 Chile had a total of 22 schools of nursing in 15 public and 7 private universities, and a convenience sample of nursing students and faculty members was chosen in three public and two private nursing schools in three regions of Chile. Regarding the criteria for appropriateness, I initially contacted these institutions by e-mail directed to a variety of nursing chairs at the university level. Then, when I was present in Chile, I conducted personal interviews with the selected nursing chairs. The criteria to select the institutions included the type of institution (public or private), the geographical location, and the number of years that the nursing program had existed (nursing programs are five years in length). Selection of fourth year students in the undergraduate nursing programs was considered optimal; however, private universities with nursing programs are new in Chile, and for the most part they did not have students close to their final year at the time of data collection. I invited all continuing faculty and fourth-year nursing students to participate in the study and estimated that this strategy would yield responses from at least 50 faculty members and 300 students.

The interviews with nursing chairs were conducted in December 2001 and March 2002. Because February is a full-holiday period in Chile throughout all university sectors, the questionnaires were completed from March to May 2002. It was not possible to find a private university with a nursing program in the North, and the South and Centre had only one qualified private nursing school with fourth year undergraduate students. Once directors of schools or departments of nursing had given approval for participation, I distributed questionnaires to continuing faculty members, along with an addressed and stamped envelope, as well as a specified return date. I then sought permission from nursing department chairs to distribute questionnaires to students and to allocate time after classes for their completion. It took approximately 30 minutes for the students to complete the questionnaires.

The procedures used to administer the questionnaires varied according to the policies of the universities and nursing departments. I sent faculty questionnaires to the public universities, which were put into mailboxes and left in offices or with secretaries of departments. In the private universities, nursing chairs took charge of distribution of the questionnaires to their faculty members and students; however, I distributed the student questionnaires. A total of 278 completed questionnaires were returned, 57 from faculty members and 221 from students. The response rate from each group is presented next.

Faculty members. From a total of 110 questionnaires distributed to faculty members, 57 were returned, for an overall response rate of 52.8% (Table 2).

Table 2

Distribution of Faculty Members Who Replied to Questionnaires, by Institution and Geographical Location

Location	Type of institution	Total approached	Total replied (*n*)	Response rate (%)
South	Public	35	23	65.7
	Private	10	6	60.0
Centre	Public	35	5	14.3
	Private	18	14	78.0
North	Public	12	9	75.0
	Private	-	-	0.0
Subtotal	Public	82	37	45.1
Subtotal	Private	28	20	71.4
Total		110	57	51.8

The response rate tended to be higher in the private universities than in the public universities. In terms of geographical location, the highest response rate, 78%, was in the Centre private. The lowest response rate, 14%, was in the Centre public. In the public university in the

centre of the country, the faculty members were less available and possibly less interested in replying because data collection occurred at the beginning of the term. In the private universities, with a seemingly more hierarchical organization of the nursing chairs, there may have been more control of the procedure, which may have influenced the response rate.

Students. From a total distribution of 300 questionnaires to students, 221 were returned, for an overall response rate of 71.3% (Table 3).

Table 3

Distribution of Students Who Replied to Questionnaires, by Institution and Geographical Location

Location	Type of Institution	Total approached	Total replied (*n*)	Response rate %
South	Public	100	89	89.0
	Private	45	23	51.1
Centre	Public	90	57	63.3
	Private	35	24	68.6
North	Public	40	28	70.0
	Private	-	-	0.0
Subtotal	Public	230	174	75.6
Subtotal	Private	80	47	58.8
Total		310	221	71.3

There was a response rate of 75.6% in the public universities and 58.8% in the private universities. In terms of geographical location, the highest response rate was 89% at the South public university; and the lowest response rate was 51.1% at the South private university. In contrast to faculty members, students in the public universities were more likely to respond than were students in the private universities.

Summary of the Sample

Forty-nine interviews and a total of 278 questionnaires contributed to the data for this research. Although it appears that faculty members in private educational institutions and students in public educational institutions were more likely to respond, no real conclusion can be drawn because only five universities were included in the sample. With these numbers, saturation of data occurred; and the criteria of comprehensiveness, completeness, saturation, and accounting for negative cases required for good qualitative research (Morse, 1999) were achieved.

Data Collection Methods

The data collection methods most appropriate for answering the research questions in this case study were questionnaires, interviews, documents, and field notes. Each of these strategies will be addressed separately.

Documents

Because health care institutions in Chile might have considered me as someone who might distract the health team members in each health care setting, participant observation was not recommended. Therefore, I viewed documents and records as keys to the cultural and organizational context of the study. As well, I sought access to the organizational charts of participating hospitals. Most of the institutions, however, lacked material, documents, or information. Some had policy and procedure manuals relevant to nurses in the institutions, but access to those was denied. I also extended the literature review to incorporate government reports and other documents that were not available when I did the preliminary review of the literature in Canada. For case studies, as Yin (1994) explained, "the most important use of documents is to corroborate and augment evidence from other sources" (p. 81). Documents are helpful to describe the context of the workplace and the nurses' relationships in the organizational context, as well as nursing issues in the larger context of the health care system and Chilean society. Therefore, some documents accessed from the Ministry of Health, PAHO, the Chilean

Nurses' Association, and the Chilean Nursing Education Association have been incorporated into the literature review in chapter 3.

Interviews

Because the case study approach provides many descriptions and interpretations by others, "in qualitative research, the interviewing is often the major source of the qualitative data needed for understanding the phenomenon under study" (Merriam, 1998, p. 91). Interviews are a type of data collection in which a one-on-one encounter takes place to allow one person to elicit information from the other person, but both parties have a purpose and a special kind of information. Patton (1990) stated that "we interview people to find out from them those things we cannot directly observe" (p. 196). Interviews are vital when we cannot observe behaviours or how people interpret the world around them. In addition, interviews also serve the purpose of collecting relevant data that deal with past events (Merriam, 1998).

I selected a semistructured interview for this case study (see Appendix C for interview guides) because I knew something about nursing practice in Chile but not enough, especially in the private health system. As Merriam (1998) pointed out, "In this type of interview either all of the questions are more flexibly worded, or the interview is a mix of more and less structured questions" (p. 74). According to Holstein and Gubrium (1997), semistructured interviews provide "a way of generating empirical data about the social world by asking [nurses] to talk about their [work]" (p. 105).

In this qualitative research, with the aid of six interview guides (Appendix C) I was able to ensure consistency in the questioning and address the research questions and the purpose of the research. At each place where participants for interviews were recruited, I requested a quiet and private room to conduct the interviews. As they progressed, it was important to transcribe and review the interview data already obtained before moving on to the subsequent interviews; hence, analysis began with the first interview, and no more than one interview was scheduled per day. Each interview was approximately 60 minutes in length, and 49 interviews were conducted.

The PhD candidacy examining committee acted as the expert panel for review of the interview guides. Translation of interview guides followed the same process as for the questionnaires, which is described later in this chapter. I made minor adjustments to the questions after the pilot interviews were conducted in January 2002.

Field Notes

A qualitative approach includes capturing insights that reveal the uniqueness of the case (Stake, 1995). Field notes may include comments on supplemental readings, field diaries (long notes written at the end of the day), and notes outlining the transformation of interactions from the raw data form to an analytic form such as insights and diagrams. Therefore, there are different kinds of notes in terms of their function. As Bond (1990) described the qualities of field notes: "They posses the attribute of both written texts and discourses. They appear to have the security and concreteness that writing lends to observation, and as written texts they would seem to be permanent, immutable records of some past occurrence" (p. 276). In this case study, field notes were used to help me to reconstruct events. Observations of the institutions as a context can be better described by using field notes that help to describe some physical situation of the organization, including charts, the actions and behaviours of the participants, and remarks and situations that the researcher considers appropriate to the research.

In addition, by using notes with dates, names, places, and times, I was able to add extra information to the interview process in the institutional setting; and I wrote the field notes on the same day as the fieldwork was done as a chronological log of what happens in the setting and with the observer. As well, I noted emerging ideas, insights, and patterns and maintained a notebook to record the day of the interviews, the names of the places, and descriptions.

Questionnaires

As previously described, I administered questionnaires to nursing faculty and students in five educational institutions. I had developed open-ended questions, and to assess the suitability

and clarity of the questions before the questionnaires were administered to students and faculty members at the institutions, I conducted a pilot test with two faculty members and five students. The questionnaires, with minor revisions after pilot testing, are found in Appendix C. As well, the committee for my candidacy examination served as assessors of the content validity of the questionnaires.

Summary of the Data Collection

Over six months, from December 2002 to June 2003, I collected the data. I spent three months in Santiago collecting half of the information and the other three months in the remaining two cities in the north and south of Chile.

Data Analysis

Data analysis is one of the most important processes in qualitative research: it provides meaning and interpretation to the final compilations. In the analysis the process of making sense out of the data, as Merriam (1998) explained, involves "consolidating, reducing, and interpreting what people have said and what the researcher has seen and read" (p. 178). In a case study, "we are trying to understand behavior, issues, and context with regard to our particular case" (Stake, 1995, p. 193). Therefore, in case studies the understanding is linked to the fact that data have been derived from questionnaires, interviews, field notes, and documents. The emphasis here has been based on the content analysis and interpretation of interviews and other data. Therefore, content analysis as an inductive analysis technique was used because it "is concerned with meaning, intentions, consequences, and context" (Downe-Wambolt, 1992, p. 314). Moreover, Holsti (1969) pointed out that content analysis "allows the researcher to make inferences about the characteristics of the text, the causes or antecedents of the message, and the effects of the communication" (p. 24).

Morse (1995a) emphasized the importance of the cognitive processes used by the researcher in inductive data analysis. These processes include *comprehension* (that is, learning

everything about the setting or the experiences of the participants by using a coding process that helps the researcher to obtain enough data to write a rich description), *synthesis* (such as merging several stories, experiences, or cases as more coding and content analysis are developed and the data are interrelated with the transcripts of the participants), *theorizing* (which will be developed from the data of the interviews based on critical analysis), and, finally, *recontextualizing* (the theoretical explanation at an abstract level).

In this research, category construction began with the first interview transcript, first set of field notes, and the first document collected. In reading through the transcript, from a postmodern view, as Fontana and Frey (2000) cautioned, one focuses on *polyphonic interviewing*, in which "the voices of the subjects are recorded with minimal influence from the researcher and are not collapsed together and reported as one, through the interpretation of the researcher" (p. 657). This implies that, although content analysis is used, individual voices and inconsistencies in the data are retained as much as possible and not lost completely through collapsed data. In the procedures, Morse and Field (1995) suggested:

> Type the interview single-spaced with a blank line between each speaker. A generous margin on both sides of the page permits the left margin to be used for coding and the researcher's own critique of the interview style, and the right margin is to be used for comments regarding the content. (p. 131)

The next set of data are scanned in the same way, and after the same procedures of data identification, a list of concepts will start to emerge. When the entire transcript has undergone exhaustive preliminary analysis, the researcher tries to compile a list of terms. The analytically meaningful and locatable segments such as persistent words, phrases, or themes within the data are teased out until saturation occurs, which is defined as "collecting data until no new information is obtained" (p. 147). With a couple of concepts reflecting the regularities and patterns, the researcher begins to create categories. At this level, data manipulation will consist of searching, sorting, retrieving, and rearranging the segments (Reid, 1992).

A multiple case study involves the collection and analysis of data from several cases. In this study it could be said that cases in three parts of Chile and in private and public health care and educational institutions were being compared. Therefore, two stages of analysis were undertaken: the within-case analysis and the cross-case analysis (Yin, 1994). In the case of the within-case analysis, each case was treated as a comprehensive case in and of itself (Merriam, 1998). As Miles and Huberman (1994) suggested, there was an analytic progression "in within-case display from exploring and describing process such as to tell a story about an specified situation, *to constructing a map*, to building a theory or model" (p. 91).

Each case was conducted independently of the others. Merriam (1998) maintained, "Each case is first treated as a comprehensive case in and of itself" (p. 194). The procedures were as follows: I handled the interview data in a similar manner to the questionnaire data by initially analyzing the staff nurses' data from each site separately and comparing them to what had been revealed by the head nurse, a high-level nurse manager, and in a review of hospital documents (within-case analysis). This was done at all sites, and I compared public and private sectors and geographical locations after all data had undergone preliminary analysis. When each case was complete and I had written the descriptions, I began the cross-case analysis by analyzing each geographical location and the public and private sectors as I became intent on building "a general explanation that fits each of the individual cases, even though the cases will vary in their details" (Yin, 1994, p. 112). I described similarities and differences and gave concrete examples, then compared all of the data with what nursing associations and Ministry of Health nurses revealed. Therefore, the cross-analysis led to the building of categories, themes, or typologies that conceptualized the data from all the cases. As Merriam (1998) noted, "A qualitative, inductive, multicase study seeks to build abstraction across the cases" (p. 195). At this point, analysis in this comparative cross study then led to more categories, themes, or an integrated framework covering multiple cases.

With regard to the questionnaire data, I analyzed the profiles of students and faculty using descriptive statistics (percentages) to develop an overall profile of the participants. The open-ended questions were analyzed for content independently, first for faculty and then for students at each site, so that comparisons between faculty and students, private and public, and geographical location could be made in the analysis. I developed a codebook to facilitate data entry. Where no differences were detected in cross-site data analysis, I then pooled the data based on geographical areas and, if warranted, collapsed the data from public and private universities into the larger pool. I wrote descriptions of the similarities and differences and provided concrete examples.

Once the questionnaire and interview data had undergone these preliminary analyses, I examined the descriptions to determine how they related to the research questions and for other, potentially more interesting questions that emerged from the data. I added information from government and hospital documents where appropriate to increase the understanding of the context in which nurses work. From such analyses, answers to the research questions were written and related to the literature. Once this was done, I addressed the question "What does this all mean?" I developed a theoretical and abstract interpretation and connected it to the theoretical perspectives described in the section on the review of the literature in this dissertation.

Translation Procedures

The data were collected in Spanish. [illegible] one of the co-supervisors has a reading knowledge of this language, I took measures to ensure that language barriers did not interfere with the research and the supervisory processes. I translated the questionnaires and interview guides into Spanish, and an external person fluent in both Spanish and English did the independent back-translation. I used the same process for the information letters and consent forms. This was a complex task because "there is no correct translation of a sentence into another language" (Werner & Campbell, 1987, p. 402). What was key was that the precise meaning be translated. It was helpful that a member of the supervisory committee is fluent in Spanish.

Because a translation of all of the data being collected would be too time consuming, it was not considered a reasonable solution. Thus, I used the following approach to ensure that I was interpreting and translating information from institutional and other documents from Spanish to English accurately. When I returned to Canada, I selected three questionnaires to translate to English from Spanish, and then the supervisory committee member who is fluent in Spanish compared both Spanish responses and English translations. Because there were discrepancies in the translation, I used another strategy and developed a codebook with categories emerging from the questionnaire data. The Spanish-speaking supervisory committee member checked 10 questionnaires for comprehensiveness of variables in the codebook and accuracy of coding before the remaining questionnaires were coded and the data entered into SPSS.

With regard to the interviews, I followed a similar process to the one for the questionnaires, but I translated only one interview, which was checked by a second bilingual person against the Spanish transcript. Because we found no substantive differences, I assumed accurate translation of the remaining interviews. Again, the products (categories, themes, etc.) of the initial analysis were done in English, although raw data remained in Spanish. In the written descriptions of what was found, I translated quotations that I used to illustrate points into English. Exceptions to this process occurred when a word or phrase was so evocative in Spanish that it needed to be included in that language, followed by an explanation in English of what it means. Because the research was conducted basically in English, I translated the quotations from Spanish to English, but looking for the meaning that makes sense in English. However, in terms of accuracy, all of the quotations were compared and checked with the member of the committee who is fluent in Spanish.

Rigor and Quality in Qualitative Case Study Research

The discussion of rigor and quality in a qualitative case study grapples with an issue that is likely to cause tension during the data analysis: How does one integrate postmodern, critical,

and feminist leanings with criteria for judging good qualitative research that are often positivist in tone? Denzin and Lincoln (2000a) clarified that qualitative research, although it is embedded in the discourse of poststructuralism and postmodernism,

> embraces two tensions at the same time. On the one hand, it is drawn to a broad, interpretative, postexperimental, postmodern, feminist, and critical sensibility. On the other hand, it can also be drawn to more narrowly defined positivist, post-positivist, humanistic, and naturalistic conceptions of human experiences and its analysis. (p. 1048)

As well, infusing the perspective of the politics of liberation into the discourse of postmodernism and poststructuralism leads to two assumptions that demand discussion: the dilemma of representation and the legitimation crisis (Denzin, 1994).

The dilemma of representation suggests that qualitative research can no longer directly capture lived experiences because it is created in the social text written by the researcher. For example, language and speech do not mirror experience. They *create experience* and, in the process of creation, constantly transform and defer that which is being described. Denzin and Lincoln (1998a) questioned, "Who is the other? Can we ever hope to speak authentically of the experience of the other or an other?" (p. 411). Therefore, it is never an accurate representation, only a textual representation of different experiences (Lather, 1993).

The second assumption, the crisis of legitimation, makes the traditional criteria for evaluating and interpreting qualitative research problematic. The crisis of legitimation is related to rethinking the meaning of validity, generalizability, and reliability (Denzin, 1994). For example, with regard to text and its validity, poststructuralism interprets validity as "a text's call to authority" (p. 313). But with validity comes power, and thus validity becomes, as Scheurich (1997) described it, a line of demarcation, "*an epistemological mask*" (p. 83) that divides good research from bad research and separates acceptable research (trustworthy) from unacceptable research (untrustworthy). Without validity (authority), however, there is no truth; and without truth there can be no trust in a text's claims to validity (legitimation). Postmodernism argues that in qualitative research there can be no criteria for judging its products (Gergen & Gergen, 2000).

In this sense, according to Denzin, "every text must be taken on its own terms. The desire to produce a valid and authoritative text is renounced" (p. 315). If we assume that validity is gone, as Denzin and Lincoln (1998a) observed, there is a political value:

> It seeks to understand how power and ideology operate through systems of discourse, asking always how worlds and texts and their meaning play a pivotal part in those decisive performances of race, class, gender [that] shape the emergent political conditions. We refer to this as the postmodern world. (p. 415)

Therefore, any good text is one that tries to depict these conditions of the concrete lives of the individuals who are participating in the study.

Classic criticisms of the case study assume that it provides little indication of the degree to which the case is representative of other cases. A case, however, must depend on the research purposes; therefore, it will be essential that the cases examined be representative of some population of cases, such as that of professional nurses in Chile. In case studies, as Denzin and Lincoln (2000b) contended, "the only generalization is: there is no generalization" (p. 27). What this suggests is that this research can make a contribution to knowledge about professional nursing in Chile, but it cannot be generalized to nursing outside of the Chilean context. That is not to say that insights gained in this research are not useful for gaining an understanding of nursing in another context.

Because the researcher accepts the two assumptions of postmodern discourse relating to legitimation and representation, validity, reliability, and generalization are not useful concepts for evaluation of the quality of the research. Therefore, how will it be known whether the final analysis and the interpretation of findings are good? Schwandt (2000) believed that it is not possible to specify criteria for good qualitative work. Others, however, have advocated criteria to assess quality, trustworthiness, and authenticity (Lincoln & Guba, 1999; Miles & Huberman, 1994) without negating the flexibility and credibility needed to construct qualitative texts in a postpositivist manner. Therefore, in this case study I followed Howe and Eisenhart's (1990) standards for qualitative research:

1. *The criterion of the fitness* between research question and data collection and analysis: The techniques of data collection such as interviews and questionnaire are appropriate to the type of research questions asked in the case study (Yin, 1994).

2. *The criterion of effectiveness*: It is not sufficient that fitting the data collection and the analysis of the data with the research questions can ensure quality, but the clarity of the procedure of the data collection and analysis must also be examined for credibility, as must the competence of the researcher.

3. *The criterion of coherence of background*: There are still no guarantees even with the credibility of the technical aspects of the research. Therefore, the explanation of the results should show some congruence with the literature reviewed and other prior knowledge.

4. *The criteria of external and internal value constraints*: The language of the findings and their implications must be done in an understandable way for the variety of individuals and groups involved, such as practicing nurses, educators, or administrators. Internal value constraints relate to ethics. The data gathered by the researcher must be collected in accordance with the principles of confidentiality, protection, and anonymity.

Therefore, in this case study, research criteria 1 and 2 were ascertained as part of the candidacy examination and the proposal defence. This is PhD-student research, and it was overseen by the supervisory committee. Criterion 3 can be judged only after data collection and analysis are complete. Comparison with the literature was an integral part of the process of analysis and interpretation and is reflected in the discussion and interpretation of the findings. This is true as well of the external value constraints portion of criterion 4. The procedures to address internal value constraints for criterion 4 are discussed in the next section.

Ethical Considerations

Research ethics boards in both Alberta and Chile reviewed this proposal. In general, qualitative research has fewer perceptible invasive procedures than does a quantitative

experimental design. Case study research, however, "shares an intense interest in personal views and circumstances" (Stake, 2000, p. 446), as is common in all qualitative research. Researcher responsibility therefore includes assurance of anonymity, confidentiality, protection from harm, and informed consent for all participants. Although the researcher can take care not to be coercive in recruiting participants, there is always the possibility of coercive practices over employees being used by institutional persons in powerful positions who grant access to data collection sites. In the case of leaders, as well as all other participants, they can refuse to answer questions. Ethical dilemmas in this research were focused on the collection of data and the dissemination of the findings. I gained access to institutions through permission of persons in authority. Such access included permission to seek participants and examine organizational documents (Appendix A). However, I did not request access to patient data. I developed clear information letters and consent forms for all interview participants (Appendix B) and included essential information for informed consent for the questionnaires on the cover sheets. Completion of the questionnaires sufficed as consent.

I used numbers to identify questionnaires, profile sheets, interview tapes, and transcripts; and I kept the names of the interview participants separate from the data. All tapes, transcripts, and questionnaires have been stored in a private, locked suitcase. I transcribed the interviews, and once the transcripts were checked for accuracy, I erased the tapes. As required, all transcripts and questionnaires will be stored in a locked place for five years.

A bilingual member of the supervisory committee checked the translations of selected interviews and questionnaires from Spanish to English. I then analyzed the results, and the supervisory committee and I had complete control over the raw data. I did not identify any institution by name, I pooled all questionnaire and interview data during the analysis, and I did not attribute quotations to specific sources.

Reflections on the Research Process

The research process was an exhausting but enriching experience. Because each institution had its own procedures for gaining access for research, I coordinated the data collection in different ways. Approaches to universities had to occur within the academic year. In hospitals, the nurses were initially hesitant and nervous about interviews, but after being interviewed for a few minutes, they became comfortable with the questions and interested in contributing to the success of the research. Moreover, they were exhilarated about sharing ideas with someone interested in their views and talked freely about issues such as family, women and work, and professional development and conflict. The combination of researcher as nurse and woman was important for the nurses' acceptance of the interview process. Interviews with leaders revealed that they were more reserved and more hesitant to share their thoughts. In general, I experienced in the data collection process a feeling that a comprehensive understanding of the settings and the working environments where nurses are practicing was emerging.

The findings are presented in the following two chapters; quantitative data are discussed in chapter 6 and qualitative data in chapter 7. Chapter 8 contains a synthesis of the findings in relation to the literature reviewed and the theoretical lens through which the data collection and analysis proceeded.

CHAPTER 6:

THROUGH THE LENS OF NURSING EDUCATION IN CHILE

Since the early 1990s Chilean nurses have been affected by changes from a predominantly public to a more privatized system in both education and health institutions. Universities in Chile have expanded, with nursing programs experiencing an increasing number of students and faculty members. For example, in the early 1990s there were 13 nursing schools with undergraduate degree programs, mainly in the public universities. Since then there has been an increased demand for nursing programs in all universities. By 2001 the total number of nursing programs increased to 22—7 in the private and 15 in the traditional public institutions—and in 2003 the number increased to 25 (CHNEA, 2003). Nevertheless, it is important to observe that during the period from 1996 to 2003, the trend toward an accelerated rate of new programs has occurred mainly in private universities.

Data from five universities (three public and two private) in three geographical regions provided a profile of the faculty members and students who participated in this study, as well as an overview of how nursing as a profession is viewed in the academic setting. This chapter is divided into the following sections: profiles of faculty members and students, faculty members' and students' descriptions of attributes of professional nursing in Chile, a comparison of similarities and differences between faculty member and student data, gender considerations, and reflections on the educational data in its entirety.

Faculty Data Profile

Information collected about faculty members relates to academic background and qualifications, clinical and teaching experience, areas taught, and affiliation with nursing associations; it did not include random sampling of institutions or of participants within institutions. Thus the data comprise a convenience sample of responses from faculty at five

institutions. With the exception of the public university in the Centre with a response rate of 14.3%, the response rate for faculty members was 60% or higher. A summary of this information is found in Tables 4 and 5 by type of institution and geographical location. Table 6 contains data relating to the affiliation with nursing associations. It is important to point out that questions relating to the reasons for responses, suggestions for change, and potential strategies were open ended and not forced choice. Categories for coding emerged from the responses.

With regard to the profile of the faculty members and the dates of their initial qualification in nursing (Table 4), about half of the faculty members who replied to the questionnaires are in the *older* category (50.9%), followed by *middle* (35.1%), and *younger* (14.0%). The qualifications of those who replied ranged from no degree to a doctoral degree. In general, the largest group has a master's degree in nursing (31.6%), concentrated mainly at the South public institution. The second largest group constitutes those with no degree (26.3%), with the majority based at the South and Centre private universities. The third largest group (12.3%) comprises members with a specialization, such as pediatrics, ophthalmology, or oncology. Differences also exist in the public universities, ranging from the highest qualification in the South and a lack of qualification in the Centre location. In the private universities a few qualified faculty members have a specialization, but none have a master's or a doctoral degree. Differences among the three types of regions are substantial in relation to faculty members with a lack of degrees at the Centre region compared with faculty members with the highest degrees in the South.

Faculty members who hold degrees in related disciplines chose to use more than one criterion; that is, those with a specialization as well as a degree. Among a total of 22 faculty members, about 50% hold degrees in other related disciplines, mainly at the master's level, with 43% holding degrees in anthropology, sociology, bioethics, or public health. Compared by type of institution, however, among the faculty members in private universities, 60% lack a baccalaureate degree, and none have a master's or a doctoral degree.

Table 4

Faculty Members' Profiles by Type of Institution and Geographical Location

	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 23		n = 6		n = 5		n = 14		n = 9		n = 57	
	n	%	n	%	N	%	n	%	n	%	n	%
A. Date of initial qualification												
Younger (after 1991)	4	17.4	2	33.0	1	20.0	1	7.3	-	0.0	8	14.0
Middle (1981-1990)	8	34.8	3	50.0	1	20.0	4	28.6	4	44.4	20	35.1
Older (1960-1980)	11	47.8	1	17.0	3	60.0	9	64.0	5	55.5	29	50.9
B. Qualification in nursing												
Not bachelor	-	0.0	3	50.0	1	20.0	8	57.1	3	33.3	15	26.3
Bachelor's degree	-	0.0	1	16.7	2	40.0	3	21.4	-	0.0	6	10.5
Specialization diploma	2	8.7	1	16.7	1	20.0	2	14.2	1	11.1	7	12.3
Master's degree	16	69.6	-	0.0	-	0.0	-	0.0	2	22.2	18	31.6
Doctorate	3	13.0	-	0.0	-	0.0	-	0.0	-	0.0	3	5.3
No response	2	8.7	1	16.7	1	20.0	1	7.3	3	33.3	8	14.0
C. Qualification in other disciplines*												
Additional courses	1	20.0	1	100.0	-	0.0	-	0.0	-	0.0	2	8.7
Bachelor's degree	1	20.0	-	0.0	-	0.0	1	14..3	-	0.0	2	8.7
Specialization	1	20.0	-	0.0	1	20.0	1	14. 3	-	0.0	3	13.0
Master's degree	1	20.0	-	0.0	1	20.0	4	57.1	4	100.0	10	43.4
Doctorate	-	0.0	-	0.0	1	20.0	1	14.3	-	0.0	2	8.7
No response	1	20.0	-	0.0	2	40.0	-	0.0	-	0.0	3	13.0
D. Clinical experience												
Short (less than 10 years)	17	74.0	2	33.5	4	80.0	10	71.4	3	33.3	36	63.1
Middle (from 10-20 years)	4	17.4	4	66.5	1	20.0	2	14.3	3	33.3	14	24.6
Long (more than 20 years)	2	8.6	-	0.0	-	0.0	2	14.3	3	33.3	7	12.3
E. Teaching experience												
Short (less than 10 years)	11	47.8	6	100.0	2	40.0	10	71.4	8	88.8	37	64.9
Middle (from 10-20 years)	4	17.4	-	0.0	-	0.0	4	28.6	1	11.1	9	15.8
Long (more than 20 years)	8	34.8	-	0.0	3	60.0	-	0.0	-	0.0	11	19.3

* Some respondents had more than one qualification.

With regard to qualifications in nursing and other disciplines, public institutions in general have a higher proportion of qualified faculty members at both the master's and the doctoral levels. However, when compared by geographical location, the South public has the highest level of qualification. Differences between institutions can be attributed to their different stages of development and their histories, as well as their geographical locations, which constrain the distribution of faculty members. Another important aspect of nursing faculty qualifications in Chile relates to the fact that the baccalaureate degree in nursing was offered at the university level only after the 1990s; the result is a mixture of degrees and university titles among professional nurses.

The clinical experience of faculty members was determined by selecting those nurses who had been working in hospitals or clinics and directly cared for patients or they have managed clinical staff. Their experience ranged from 0 to 30 years in hospitals or clinics. The majority of the faculty members have less than 10 years of clinical experience (63.1%), with middle clinical experience at 24.6% and long at 12.3%. No substantial differences were found between private and public universities. Nevertheless, in the South private university, the highest proportion had middle clinical experience, indicating more than 10 years in clinical practice. It is likely that new private universities prefer to hire instructors with longer practical clinical experience. It has been common in Chile for faculty members to start their teaching career after only a few years of practice. Often very strong graduates are pursued to assume faculty positions early in their nursing careers.

Overall, with regard to the teaching experience of faculty members who replied to the questionnaires, 65% of the faculty members have less than 10 years of university teaching experience, 25% have between 10 and 20 years of teaching experience, and 12% have long teaching experience of more than 20 years. By type of institution, those faculty members in private universities (75%) generally have fewer years of teaching experience, perhaps because private universities began to develop only a few years ago (less than 10 years). However, faculty

members in the public universities have a wide range in the length of their teaching experience, except at the northern site, where 63.1% of faculty members have less than 10 years of teaching experience; the nursing school opened only a few years ago. Thus, the distribution of teaching experience varies and is most likely related to the length of time that nursing programs have been offered in specific geographical locations and in the public and private sectors.

The distribution of types of courses taught by faculty members who replied to the questionnaires (Table 5) are most commonly in the areas of *adult, community*, and *child care courses*. This trend can be seen in the same proportion in the public, but not at the South private universities, where faculty members or instructors come mainly from practice areas with low experience in teaching and fewer qualifications (see Table 4). Among all of the respondents, those in public universities have taught a greater variety of courses in combination with education, research, and management courses than those in the private universities have. Faculty members also reported "other" types of courses, including a variety of courses in public health (e.g., epidemiology), medicine (e.g., oncology), and social sciences (e.g., anthropology).

In terms of their overall affiliation with the Chilean Nurses' Association (CHNC—Chilean Nursing College; Table 6), 57.8% of the faculty are members. With respect to distribution by geographical location and type of institution, the faculty members with the highest affiliation are based in the South region in both public and private universities (87% and 83%, respectively). In public universities in the Centre and North regions, faculty members tend to have much lower affiliation (20% and 22%, respectively). These differences in affiliation are substantial in the public universities—three times higher in the South than in the Centre and North for CHNEA. In general, this finding of 57.8% affiliation is higher than that reported by Westerman (1999) for one southern region of Chile regarding the numbers of professional nurses affiliated with the nursing association (49%).

Table 5

Courses Taught by Faculty Members by Type of Institution and Geographical Location

	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 23		n = 6		n = 5		n = 14		n = 9		n = 57*	
Courses taught*	n	%	n	%	n	%	n	%	n	%	n	%
	(52)	43.7	(8)	6.7	(11)	9.2	(27)	22.7	(21)	17.6	(119)	100
Adult care	10	19.2	4	50.0	2	18.2	4	14.8	5	23.8	25	21.0
Community care	8	15.4	-	0.0	2	18.2	5	18.5	4	19.0	19	15.9
Child care	5	9.6	-	0.0	2	18.2	4	14.8	3	14.3	14	11.7
Education	6	11.5	-	0.0	1	0.9	2	7.4	1	4.8	10	8.4
Maternal care	3	5.8	-	0.0	1	0.9	4	14.8	1	4.8	9	7.5
Senior care	6	11.5	1	12.5	-	0.0	1	3.7	1	4.8	9	7.5
Research	5	9.6	-	0.0	1	0.9	2	7.4	1	4.8	9	7.5
Management	3	5.8	-	0.0	-	0.0	-	0.0	3	14.3	6	5.0
Mental health	2	3.8	2	25.0	1	0.9	1	3.7	-	0.0	6	5.0
Ethics	3	5.8	-	0.0	1	0.9	-	0.0	-	0.0	4	3.4
Other	1	1.9	1	12.5	-	0.0	4	14.8	2	9.5	8	6.7

* Most respondents teach more than one course.

Table 6

Faculty Members Affiliated With Chilean Nurses' Associations

	CHNC (Chilean Nurses' Association)		CHNEA (Chilean Nursing Education Association)	
Affiliation	n = 57	%	n = 57	%
South-public (n = 23)	20	87.0	19	82.6
South-private (n = 6)	5	83.0	-	0.0
Centre-public (n = 5)	1	20.0	4	80.0
Centre-private (n = 14)	5	35.7	8	57.1
North-public (n = 9)	2	22.2	2	22.2
Subtotal	33	57.8	33	57.8

Membership in the CHNC has been voluntary since a 1982 law governing all professional associations was enacted. Therefore, when nurses graduate, they can choose to become affiliated or not. The CHNC is the only nursing association in Chile, and it is charged with protecting both the population and professional interests. In 2004, it is estimated that more than 8,000 professional nurses are working throughout the country in different jobs in the public and private institutions, of whom approximately 3,500 are affiliated with the CHNC—approximately 40%. The Chilean Nurses' Association does not have control over the number of professional nurses practicing, especially in the private sector, where they are dispersed in many different workplaces. The lack of a legal requirement for licensure or registration to practice as a nurse means that there is no up-to-date list of persons working as professional nurses in Chile.

Another association (which has had a new name since 1998) is the Chilean Nursing Education Association (CHNEA; formerly Society of Chilean Nursing Schools). With respect to the distribution of members by region and type of institution, the South public university has the highest proportion (82.6%), followed by the Centre public university at 80% and the Centre private university at 57.1%. Moreover, no faculty members at the South private university are affiliated with CHNEA, and there is low affiliation at the North public university. The distribution of affiliation with the CHNEA needs to be explored further because there is no literature available on why faculty members decide to be or not to be affiliated. Although the CHNEA is a consulting organization rather than an accreditation authority, it is still an important professional association with regard to providing guidance for nursing curricula in undergraduate and graduate nursing programs at the university level. It is apparent that the CHNEA needs to strengthen connections with new faculty members and new nursing schools in order to enrol more members.

Faculty Members' Visions of Nursing as a Profession in Chile

This section relates to faculty members' views of nursing as a profession and reasons to support nursing as a profession, as well as changes and strategies suggested (see Tables 7, 8, 9, and 10).

Nursing is viewed as a profession by almost all faculty members who replied to the questionnaires (almost 95%; Table 7). Categorized by geographical location, faculty members who agreed came from both South and Centre public and private universities, whereas the faculty members who disagreed all came from the North public university. This substantial difference is perhaps because this nursing school was opened in 1993, with few years of development and few graduates, but it would be interesting to explore these dissenting perceptions further; however, this university also has the lowest affiliation with the CHNA and the CHNEA.

Table 7

Faculty Members Who View Nursing as a Profession

Geographical location	Yes (n = 57)	%
South-public (n = 23)	23	100.0
South-private (n = 6)	6	100.0
Centre-public (n = 5)	5	100.0
Centre-private (n = 14)	14	100.0
North-public (n = 9)	6	66.6
Total	54	94.7

Faculty members selected a variety of reasons for their belief that nursing is a profession (Table 8); the main reason was "*theoretical and scientific knowledge.*" The second and third most frequently stated reasons are that it is a "*response to specific needs*" and that it "*requires study at university level.*" Other reasons that support the claim that nursing is considered a profession

included "*own knowledge*," "*recognized role by society*," and "*clear goal for practice*." "*Autonomy*" *and* "*leadership*" were cited by only a few respondents. There were some differences in the distribution of reasons. For example, in the South public university a greater number of reasons were given than at the Centre public university. As well, the respondents from the Centre private university gave more reasons than did the respondents from the South private university.

Table 8

Faculty Members' Reasons for Believing that Nursing Is a Profession

	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 23		n = 6		n = 5		n = 14		n = 9		n = 57	
Reasons*	n	%	n	%	n	%	n	%	n	%	n	%
Theoretical & knowledge	17	20.3	6	35.3	4	29.0	10	24.4	5	22.7	42	23.6
Respond to specific needs	11	13.1	1	5.9	3	21.4	5	12.2	4	18.2	24	13.5
Requires university	8	9.5	1	5.9	1	7.1	8	19.5	3	13.6	21	11.8
Own knowledge based	11	13.1	2	11.7	1	7.1	1	2.4	3	13.6	18	10.1
Recognized role in society	9	10.7	3	17.6	-	0.0	2	4.8	1	4.5	15	8.4
Clear goal for practice	9	10.7	-	0.0	1	7.1	1	2.4	1	4.5	12	6.7
Associations	5	5.4	-	0.0	1	7.1	3	7.3	2	9.0	11	6.2
Structured curriculum	7	8.3	1	5.9	-	0.0	2	4.8	-	0.0	10	5.6
Leadership	1	1.2	2	11.7	-	0.0	3	7.3	-	0.0	6	3.3
Autonomy	2	2.4	-	0.0	-	0.0	1	2.4	2	9.0	5	2.8
Requires long studies	1	1.2	1	5.9	-	0.0	2	4.8	-	0.0	4	2.2
Others	3	3.6	-	0.0	3	21.4	3	7.3	1	4.5	10	5.6
Total	(84)	7.9	(17)	9.6	(14)	7.8	(41)	3.0	(22)	2.3	(178)	100.0

* Respondents provided more than one reason.

The three main changes envisioned by faculty members in nursing for strengthening professional status (Table 9) are "*more graduate programs*," "*more communication with society*," and "*enhanced professional image*." With respect to the most frequently selected envisioned changes, faculty members in the public universities supported mainly "*enhanced professional image*," "*more graduate programs*," and "*communication to society*." Faculty members from the Centre private university identified "*research participation*" as a need. In the Centre public university no faculty members reported a need for "*more graduate programs*." These minor differences between universities may be due to the context and development where they are working and their experiences of what can be important to change.

When faculty members envisioned strategies (Table 10) to effect changes, the majority of the responses were in the same order: "*More graduate programs*," "*more effective nursing association*," and "*more professional development*." When faculty members are categorized by type of institution, a little difference in ranking occurred between public and private universities. Faculty members from private and public institutions appear to have different priorities; for example, private university respondents tend to look outside the university setting to the nursing associations, media, and new opportunities; whereas public university respondents tend to look inside the university setting with suggestions such as increasing the number or size of nursing degree programs. Certain reasons also carry lower priority; for example, "*incorporating nursing in LOCE*," which is related to a High Education Law—a law in national education that gives legal support to keep nursing programs at the university level—and "*accreditation*," which is a normative evaluation issue in nursing programs at the university level. Less often selected were strategies to "*promote autonomy*," "*political action*," and "*faculty status*." In general, faculty members see professional development—more degrees or higher qualifications and opportunities—as strategies, along with more effective nursing associations.

Table 9

Faculty Members' Suggestion for Changes Needed to Strengthen the Professional Status of Nurses

	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 23		n = 6		n = 5		n = 14		n = 9		n = 57*	
Changes suggested*	n	%	n	%	n	%	n	%	n	%	n	%
More graduate programs	10	15.1	2	20.0	-	0.0	4	15.4	2	8.3	18	13.2
Communication to society	8	12.1	3	30.0	1	10.0	2	7.7	2	8.3	16	11.8
Enhance profess. Image	8	12.1	1	10.0	2	20.0	2	7.7	3	12.5	16	11.8
Research participation	3	4.5	-	0.0	-	0.0	5	19.2	2	8.3	10	7.4
Exhibit leadership	3	4.5	-	0.0	1	10.0	2	7.7	3	12.5	9	6.6
Participation in policy	5	7.5	-	0.0	-	0.0	2	7.7	2	8.3	9	6.6
Attitude Profess. change	5	7.5	1	10.0	-	10.0	-	0.0	2	8.3	8	5.9
Improve labour conditions	3	4.5	-	0.0	-	0.0	3	11.5	2	8.3	8	5.9
More accreditation	1	1.5	-	0.0	-	0.0	2	7.7	3	12.5	6	4.4
Team work	1	1.5	-	0.0	2	20.0	-	7.7	2	8.3	5	3.7
Apply nursing process	4	6.1	-	0.0	-	0.0	1	3.8	-	0.0	5	3.7
Exclusively university program	2	3.0	2	20.0	-	0.0	-	0.0	-	0.0	4	2.9
Quality of students	1	1.5	-	0.0	1	10.0	1	3.8	-	0.0	3	2.2
Political action	3	4.5	-	0.0	-	0.0	-	0.0	-	0.0	3	2.2
Others	9	13.6	1	10.0	3	30.0	2	7.7	1	4.2	16	11.7
Total	(66)	48.5	(10)	7.4	(10)	7.4	(26)	19.1	(24)	17.6	(136)	100.0

* Respondents often suggested more than one reason.

Table 10

Faculty Member Strategies Envisioned for Enhancing Nursing as a Profession

	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 23		n = 6		n = 5		n = 14		n = 9		n = 57*	
Strategies suggested*	n	%	n	%	n	%	n	%	n	%	n	%
More graduate programs	10	13.2	-	0.0	-	0.0	2	6.5	4	13.8	16	10.6
Effective nursing associations	8	10.5	2	25.0	-	0.0	3	9.7	3	10.3	16	10.6
More professional develop.	7	9.2	-	0.0	-	0.0	4	12.9	5	17.2	16	10.6
Restructuring curriculum	6	7.9	1	16.7	2	33.3	4	12.9	1	3.4	15	10.0
Increased nursing research	7	9.2	-	0.0	-	0.0	3	9.7	2	6.9	12	8.0
Communication to society	5	6.5	2	25.0	-	0.0	3	9.7	-	0.0	10	6.6
Promotion of leadership	5	6.5	-	0.0	-	0.0	1	3.2	3	10.3	9	6.0
Coordination among nurses	3	3.9	-	0.0	-	0.0	4	12.9	2	6.9	9	6.0
Increased self-esteem	5	6.5	-	0.0	-	0.0	1	3.2	2	6.9	8	5.3
Participation in policy development.	4	5.2	1	16.7	1	16.6	1	3.2	1	3.4	8	5.3
More financial support	4	5.2	-	0.0	-	0.0	2	6.5	-	0.0	6	4.0
Promotion of autonomy	1	1.3	1	16.7	1	16.6	1	3.2	-	0.0	4	2.7
Incorporating of nursing in LOCE**	2	2.6	-	0.0	-	0.0	-	0.0	1	3.4	3	2.0
Accreditation	1	1.3	-	0.0	-	0.0	-	0.0	1	3.4	2	1.3
Increased faculty status	2	2.6	-	0.0	-	0.0	-	0.0	-	0.0	2	1.3
Increased political action	2	2.6	-	0.0	-	0.0	-	0.0	-	0.0	2	1.3
Others	4	5.2	1	16.7	2	33.3	4	12.9	1	3.4	12	8.0
Total	(76)	50.6	(8)	5.3	(6)	4.0	(31)	20.7	(29)	19.3	(150)	100.0

* Respondents often suggested more than one reason.

** LOCE = Chilean Educational Organic Constitutional Law

Additional comments from faculty members helped to clarify details of the strategies toward changes. They included suggestions such as to "*enhance nursing identities*," "*plan strategy*," "*involve new graduates*," and "*network internationally*." Other respondents commented, "*There is a lack of health ministry representatives*," "*Nurses should not be so competitive among themselves*," "*Nurses must take off as a profession*," "*We are responsible for our status*," and "*Assertiveness in nursing should be more visible*." Therefore, a rich variety of suggestions were made as potential strategies to move nursing forward as a profession.

Student Data Profile

Profiles of the students by type of institution (Table 11) were determined according to age, reasons for studying nursing, satisfaction with studying nursing, reasons for satisfaction in nursing programs, and expected future position. Here, data collection also did not include random sampling of institutions or of participants within institutions. Thus, the data reflect students from five convenience sample institutions who chose to respond to the questionnaires. Their response rates ranged from 51% to 89%.

Table 11

Students' Profile by Type of Institution and Geographical Location by Age

	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 89		n = 23		n = 57		n = 24		n = 28		n = 221	
Years of age	n	%	n	%	n	%	n	%	n	%	n	%
20-25	81	91.0	22	95.6	53	92.3	23	95.4	19	67.8	198	89.6
26 to 30	7	7.8	1	4.3	1	1.8	1	4.2	6	1.4	16	7.3
More than 30	1	1.1	-	0.0	3	5.3	-	0.0	3	10.7	7	3.2
Total	(89)	40.3	(23)	10.4	(57)	25.8	(24)	10.6	(28)	2.7	(221)	100.0

Eighty-nine percent of the 221 students were 20 to 25 years old. When they were compared according to the three categories of age and type of institution, no differences were found between age segments. These similarities occur because in Chile most students enter university at about 17 to 18 years of age, and the expected age of a student in his/her fourth year (the sample for this research) then is older than 20 but younger than 25 years.

The three main reasons that students decided to choose nursing programs (Table 12), in order of importance, are "*altruism*," "*holistic programs*," and "*second option.*" With regard to altruism, it was conceptualized as service or help to others; the holistic program was conceived as having comprehensive knowledge that includes science and humanistic approaches; and, finally, the second option in the Chilean public university selection system is related to the second selection according to national scores, which means that nursing was not the first preference. First choices could have been medicine, dentistry, or another program. Comparing sectors, the main reasons given by students in public universities are the same. In private universities, however, students selected second the notion of "*personal compatibility.*" These differences can perhaps be explained by the selection process at public universities, which is based on national scores on the Academic Aptitude Test (PAA). Private universities do not use the same process, so the decision is based more on personal interest and financial support. In public universities, students are admitted according to scores. Other interesting reasons provided by students included job diversity and desire for a valuable career.

When asked about their satisfaction with nursing programs in the five universities (Table 13), 92.8% of the students were happy with their decision to study nursing. The proportions are essentially the same in both private (92%) and public (93%) institutions and by geographical location. The respondents at the Centre public and private universities reported the highest level of satisfaction (98.2%).

Table 12

Students' Profile by Type of Institution and Geographical Location According to Reasons for Choosing Nursing

	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 89		n = 23		n = 57		n = 24		n = 28		n = 221*	
Reasons to choose nursing	n	%	n	%	n	%	n	%	n	%	n	%
Altruism	54	43.5	12	44.4	33	43.4	14	51.9	16	40.0	129	43.9
Holistic program	21	16.9	3	11.1	12	15.8	4	14.8	5	13.0	45	15.3
Second option.	20	16.3	2	7.4	7	9.2	4	14.8	2	5.0	35	11.9
Personal compatibility	6	4.8	8	29.6	6	7.9	4	14.8	8	20.0	32	10.9
Job diversity	12	9.7	2	7.4	7	9.2	-	0.0	1	2.5	22	7.5
Want a valuable career	5	4.0	-	0.0	7	9.2	1	3.7	6	15.0	19	6.5
Other	6	4.8	-	0.0	4	5.2	-	0.0	2	5.0	12	4.1
Total	(124)	42.1	(27)	9.2	(76)	25.9	(27)	9.2	(40)	13.6	(294)	100.0

* Respondents often give more than one reason.

Table 13

Students' Profile by Type of Institution and Geographical Location According to Their Expression of Satisfaction With the Nursing Program

Geographical location	Yes (n = 221)	%
South-public (n = 89)	80	89.9
South-private (n = 23)	21	91.3
Centre-public (n = 57)	56	98.2
Centre-private (n = 24)	23	95.8
North-public (n = 28)	25	89.3
Total	205	92.8

Of the students reporting satisfaction with the nursing programs (Table 14), 32.1% chose the reason "*personal compatibility*" as the main reason. The second and third reasons were "*because of service to others*" (22.9%) and "*holistic program*" (9.7%). Students cited the "*holistic program*" as a different dimension, such as biopsychosocial and humanistic, of nursing programs. "*Personal growth*" was another reason that was given frequently. Responses under the category *Others* included, *"It is a humanistic program*" and "*In nursing you can better appreciate life.*" In general, the students saw nursing as a humanistic service that matched their inclinations. "*Contact with people*" fits with the categories of "*Service to others*" and "*Holistic programs*" in that it also portrays a humanistic focus.

Table 14

Students' Reasons for Satisfaction in the Nursing Program by Type of Institution and Geographical Location

	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 89		N = 23		n = 57		n = 24		n = 28		n = 221*	
Reasons for satisfaction*	n	%	n	%	n	%	n	%	n	%	n	%
Personal compatibility	44	27.3	13	36.1	38	34.0	11	26.2	20	47.6	126	32.1
Service to others	39	24.2	9	25.0	23	20.5	10	23.8	9	21.4	90	22.9
Holistic program	18	11.2	-	0.0	14	12.5	3	7.1	3	7.1	38	9.7
Personal growth	16	9.9	4	11.1	7	6.3	6	14.3	4	9.5	37	9.4
Skill & knowledge	15	9.3	3	8.3	9	8.0	5	11.9	3	7.1	35	8.9
Job diversity	15	9.3	4	11.1	8	7.1	-	0.0	3	7.1	30	7.6
Contact with people	7	4.3	-	0.0	8	7.1	-	0.0	-	0.0	15	3.8
Team work	2	1.2	2	5.5	4	3.6	4	9.5	-	0.0	12	3.1
Other	5	3.1	1	2.7	1	0.9	3	7.1	-	0.0	10	2.5
Total	(161)	41.0	(36)	9.2	(112)	28.5	(42)	10.7	(42)	10.7	(393)	100.0

* Respondents often gave more than one reason.

The most frequently stated expected or desired future position (Table 15) was a "*head nurse*" (23.3%); the second was "*adult care*" (14.3%). The category "*not sure*" was third at 11.9%. Similar reasons were given by students in both private and public universities. They selected a variety of future positions. A few students (2.7%) chose "*anything but administration.*" Other interests included "*high government position*" (2.7%)," "*rural/primary care*" (2.7%), and "*community*" (5.9%) positions, which indicates that hospital nursing may be perceived as a more attractive career. This was an open-ended question and the results are difficult to interpret because clinical areas were conflated with levels of advancement within nursing in the responses.

The questions would need to have been worded more precisely to obtain the most meaningful results.

Table 15

Students' Aspirations for Future Positions in Nursing by Type of Institution and Geographical Location

	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 89		n = 23		n = 57		n = 24		n = 28		n = 221*	
Future position*	n	%	n	%	n	%	n	%	n	%	n	%
Head nurse	20	15.5	12	40.0	26	28.6	8	22.8	12	24.0	78	23.3
Adult care nurse	19	14.7	1	3.3	19	20.9	5	14.3	4	8.0	48	14.3
Not sure	20	15.5	4	13.3	9	9.9	4	11.4	3	6.0	40	11.9
Pediatric nurse	11	8.5	1	3.3	7	7.7	7	20.0	1	2.0	27	8.1
Specialist/ graduated	9	7.0	1	3.3	5	5.5	7	20.0	5	10.0	27	8.1
Community nurse	10	7.7	4	13.3	2	2.2	1	2.8	3	6.0	20	5.9
Manager nurse	5	3.8	1	3.3	4	4.4	1	2.8	5	10.0	16	4.8
Faculty member	5	3.8	1	3.3	6	6.6	-	0.0	3	6.0	15	4.5
Direct care	7	5.4	1	3.3	3	3.3	1	2.8	3	6.0	15	4.5
Anything but administrator	7	5.4	1	3.3	1	1.0	-	0.0	-	0.0	9	2.7
Government high position	3	2.3	-	0.0	4	4.4	1	2.8	1	2.0	9	2.7
Rural/primary care nurse	2	1.5	2	6.6	1	1.0	-	0.0	4	8.0	9	2.7
Senior care	2	1.5	1	3.3	-	0.0	-	0.0	2	4.0	7	2.1
Other	9	7.0	-	0.0	1	1.0	1	2.8	4	8.0	15	4.5
Total	(129)	38.5	(30)	9.0	(91)	27.2	(35)	10.4	(50)	14.9	(335)	100.0

* Respondents gave more than one reason.

Only 11.4% of the student respondents are members of any nursing student association (Table 16), with a range in affiliation from 2.2% (1 student) at the Centre public university to between 11.3% and 13.5% at other sites. The data therefore reveal low participation at all sites and almost no participation at one site.

Table 16

Students' Affiliation with Nursing Student Association

Geographical location	Yes (n = 221)	%
South-public (n = 89)	11	12.4
South-private (n = 23)	5	11.3
Centre-public (n = 57)	1	2.2
Centre-private (n = 24)	3	13.5
North-public (n = 28)	3	11.3
Total	23	11.4

Among the three main reasons that students were not affiliated with the Nursing Student Association (NSA; Table 17), 33.3% cited "*a lack of time*" as the main reason, 22.8% stated "*a lack of knowledge*" about these associations, and 13% stated "*a lack of importance*." Differences between public and private universities in this regard were not found. Because the NSA was established in all Chilean universities only in 1997, students are still largely unaware of it. There may be more participation in the NSA at the public universities than at the private universities, but the differences are slight. Students reported a lack of time and a lack of awareness as the greatest barriers to membership. When it is considered that all five universities where the study was undertaken have nursing associations, it is evident that a high proportion of students are not yet willing members. As for secondary reasons for not joining, the students selected "We *do not*

have a strong voice," "*It is a lack of unity*," "*It is too much responsibility*," and "*Dislike of long meetings.*" It seems that students do not trust the associations to defend their collective interests.

Table 17

Students' Reasons for Lack of Affiliation With the Nursing Student Association

	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 89		N = 23		n = 57		n = 24		n = 28		n = 221*	
Reasons not to be affiliated with NSA*	n	%	n	%	n	%	n	%	n	%	n	%
Lack of time	39	38.6	10	30.3	30	39.4	3	8.3	13	33.3	95	33.3
Lack of knowledge	22	21.8	11	33.3	15	19.7	15	41.6	2	5.1	65	22.8
Lack of importance	10	9.9	2	6.1	13	17.1	5	1.4	7	17.9	37	13.0
Association weakness	11	10.9	2	6.1	4	5.3	-	0.0	8	20.5	25	8.7
Lack of self-confidence	3	2.9	3	9.0	4	5.3	4	1.1	2	5.1	16	5.6
Lack of awareness	5	4.9	-	0.0	4	5.3	3	8.3	2	5.1	14	4.9
I believe it does not exist	2	1.9	1	0.9	3	3.9	3	8.3	-	0.0	9	3.2
I am not sure	1	0.9	1	0.9	2	2.6	2	5.5	-	0.0	6	2.1
Laziness	3	2.9	2	6.1	-	0.0	-	0.0	-	0.0	5	1.8
Other	5	4.9	1	0.9	1	1.3	1	2.7	5	12.8	13	4.5
Total	(101)	35.4	(33)	11.6	(76)	26.7	(36)	12.6	(39)	13.7	(285)	100.0

* Respondents often give more than one reasons.

At the time of data collection the NSA had been in existence for more than four years. Low participation may reflect a lack of knowledge and poor understanding of the importance of associations. Although the CHNC has been working closely with students since 1998, there is

still a need for much more work to enhance this process. It may be that a public relations campaign to advertise the benefits of professional association membership would be useful.

Students' Visions of Nursing as a Profession

In this section the students were asked what they thought of nursing as a profession (Table 18). Approximately 84% supported the vision that nursing in Chile is a profession. When viewed in terms of geographical location, some differences in students' responses were found. For example, 10.7% of the students at the North public university compared with 98.2% of the students at the Centre public university considered nursing a profession. These findings are similar to those of the faculty members at the North university, who also had the same low perception. It is not surprising that there would be such parallel views because the opinions of faculty members would likely influence students' thinking.

Table 18

Students' Visions of Whether Nursing Is a Profession

Geographical location	Yes (n = 221)	%
South-public (n = 89)	84	94.4
South-private (n = 23)	20	87.0
Centre-public (n = 57)	56	98.2
Centre-private (n = 24)	23	95.8
North-public (n = 28)	3	10.7
Total	186	84.2

For students, the first reason to support the statement that nursing is a profession (Table 19) was that it "*requires a university education.*" The second reason was that it is "*based on knowledge*." The third reason given was that it plays a "*unique role in the health service*." The students' vision of a profession was related mainly to having a university education, having a

need for knowledge, and assuming a unique role for nurses in the health system. There were some variations in the reasons at the North public university and the South private university, but there were no differences found by type of institution. A minority of reasons were based on "*inclusion in Sanitary Code*," "*requirements and rules*," and "*Code of Ethics*," or legal support of a profession. However, they mentioned "*autonomy*" and "*recognition by society*" less often. In general, students' vision of a profession is one that is based on knowledge and related to a high level of education gained at the university level.

Table 19

Students' Reasons to Support Nursing as a Profession

Reasons to support nursing as a profession*	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 89		n = 23		n = 57		n = 24		n = 28		n = 221*	
	n	%	n	%	n	%	n	%	n	%	n	%
Requires university education	44	31.4	2	9.0	30	30.0	16	38.0	8	17.0	100	28.5
Based on knowledge	30	21.4	5	22.7	27	27.0	11	26.2	18	38.3	91	25.9
Unique role in health system	26	18.6	4	18.0	24	24.0	7	16.6	10	21.3	71	20.2
Requires long training	10	7.1	1	4.5	5	5.0	6	14.3	1	2.1	23	6.5
It is in the Sanitary Code	10	7.1	6	27.2	-	0.0	-	0.0	-	0.0	16	4.6
Has requirements and rules	1	0.7	-	0.0	10	10.0	1	2.4	1	2.1	13	3.7
Has a code of ethics	5	3.6	-	0.0	1	1.0	1	2.4	5	0.6	12	3.4
It is autonomous	8	5.7	2	9.0	-	0.0	-	0.0	2	4.2	12	3.4
It has recognition by society	1	0.7	1	4.5	2	20.0	-	0.0	-	0.0	4	1.4
Other	5	3.6	1	4.5	1	10.0	-	0.0	2	4.2	9	2.5
Total	(140)	39.8	(22)	6.3	(100)	28.5	(42)	11.9	(47)	13.4	(351)	100.0

* Respondents gave more than one reason.

When asked about the definition of a profession (Table 20), the respondents identified several, primarily an occupation that is "*based on knowledge*," "*high level of education," and "based on theories."* Theoretical knowledge gained at the university level is seen as the main part of a profession. Other definitions of a profession included "*specific role*," "*has rules & requirements*," "*benefit to community*," and "*societal recognition*." The students mentioned "*Autonomy*" and "*Code of Ethics*" less frequently, with "*vocation*" as the classical transition to a profession mentioned even less often. The largest proportion of responses was from students at the South and Centre public universities.

The students maintained that the main criteria of a profession (Table 21) are "*based on applied knowledge*," "*high level of education*," and "*legal support*." Their mention of the third criterion, "*legal support*," was perhaps based on the influences of the new Sanitary Code Law in Chile, in which professional nurses have been included since 1998. It was a long campaign to put professional nursing into a legal framework, and students were completely involved during this period of time. Other criteria such as "*high responsibility*," "*recognition by society*," and "*benefit to society*" were mentioned less. "*Autonomy*" and "*Code of Ethics*" again were less frequently chosen. Students emphasized the level of education and knowledge that nursing as a profession requires; however, few saw autonomy and a Code of Ethics as integral dimensions of a profession.

Table 20

Students' Definition of a Profession

Definition of profession*	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 89		N = 23		n = 57		n = 24		n = 28		n = 221*	
	n	%	n	%	n	%	n	%	n	%	n	%
Based on knowledge	82	34.6	18	31.5	49	32.2	20	32.8	27	32.1	196	33.1
High level of education	52	21.9	4	7.0	23	15.1	11	18.0	16	19.0	106	17.9
Based on theories	25	10.5	10	17.5	25	16.4	8	13.1	8	9.5	76	12.3
Is a program-specific role	19	8.0	2	3.5	19	12.5	9	14.5	12	14.3	61	10.3
Has rules & requirements	15	6.3	6	10.5	11	7.2	7	11.8	4	4.7	43	7.3
Benefit to community	13	5.5	4	7.0	6	3.9	3	4.9	6	7.1	32	5.4
Societal recognition	11	4.6	2	3.5	9	5.9	-	0.0	2	2.4	24	4.1
Autonomy	10	4.2	3	5.2	2	1.3	-	0.0	4	4.8	19	3.2
Has a code of ethics	3	1.2	5	8.7	3	1.9	-	0.0	3	3.6	14	2.3
Vocation	3	1.2	3	5.2	2	1.3	2	3.3	-	0.0	10	1.7
Other	4	1.7	-	0.0	3	1.9	1	1.6	2	2.4	10	1.7
Total	(237)	40.1	(57)	9.6	(152)	25.7	(61)	10.3	(84)	14.2	(591)	100.0

* Respondents gave more than one reason.

Table 21

Students' Criteria for a Profession

Criteria for a profession*	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 89		n = 23		n = 57		n = 24		n = 28		n = 221*	
	n	%	n	%	n	%	n	%	n	%	n	%
Based on applied knowledge	47	42.3	4	12.5	37	39.4	14	48.2	16	28.1	118	36.5
High level of education	27	24.3	5	15.6	22	23.4	2	6.9	8	14.0	64	19.8
Legal support	9	8.1	1	3.1	6	6.4	1	3.4	5	8.8	22	6.8
High responsibility	4	3.6	5	15.6	4	4.3	3	10.3	5	8.8	21	6.5
Recognition by society	6	5.4	2	6.3	7	7.4	1	3.4	5	8.8	21	6.5
Benefit to society	5	4.5	2	6.3	6	6.4	2	6.9	4	7.0	19	5.9
Have a code of ethics	3	2.7	6	18.7	2	2.1	2	6.9	6	10.5	19	5.9
Autonomy	6	5.4	4	12.5	1	1.1	2	6.9	4	7.0	17	5.3
I don't know	2	1.8	2	6.3	-	0.0	2	6.9	1	1.8	7	2.1
Other	2	1.8	1	3.1	9	9.6	-	0.0	3	5.7	15	4.6
Total	(111)	34.4	(32)	9.9	(94)	29.1	(29)	8.9	(57)	17.6	(323)	100.0

* Respondents gave more than one reason.

Students envisioned the following main changes to enhance the professional status of nursing (Table 22): "*increase autonomy*," "*educate society via media*," and "*better professional attitude*." Students' suggestion to "*increase autonomy*" as the main change required is an important declaration. "*Educating society through the media*" may enhance the image of nurses as professionals. A change in the professional attitudes of nurses and faculty members "*to behave as autonomous nurses*" and "*to recognize that we are an independent profession*"—not only at the practical, but also at the educational level was also advocated.

Table 22

Changes Envisioned by Students to Enhance the Professional Status of Nurses

	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 89		n = 23		n = 57		n = 24		n = 28		n = 221*	
Changes suggested*	n	%	n	%	n	%	n	%	n	%	n	%
Increase autonomy	24	14.0	10	24.4	31	22.3	7	17.5	11	19.3	83	18.5
Educate society by media	26	15.2	1	2.4	34	24.5	5	12.5	5	8.8	71	15.8
Improve professional attitude	19	11.1	6	14.6	12	8.6	3	7.5	8	14.0	48	10.7
Increase number of graduates	15	8.7	3	7.3	11	7.9	5	12.5	2	3.5	36	8.0
Increase nursing influence in health	11	6.4	3	7.3	10	7.2	2	5.0	6	10.5	32	7.1
Strengthen nursing association	11	6.4	3	7.3	4	2.9	1	2.5	8	14.0	27	6.0
Increase recognition & respect	10	5.8	3	7.3	9	6.5	2	5.0	-	0.0	24	5.4
Review curriculum	10	5.8	1	2.4	7	5.0	2	5.0	3	5.2	23	5.1
Increase empathy	10	5.8	1	2.4	2	1.4	2	5.0	2	3.5	17	3.8
Increase salaries	9	5.3	-	0.0	3	2.1	1	2.5	1	1.8	14	3.1
Recover human approach	6	3.5	3	7.3	1	0.7	1	2.5	1	1.8	12	2.7
Unify nursing	5	2.9	-	0.0	6	4.3	1	2.5	-	0.0	12	2.7
Use & apply nursing process	2	1.2	2	4.9	-	0.0	3	7.5	3	5.2	10	2.2
Increase mobility in public system.	3	1.8	3	7.3	-	0.0	1	2.5	1	1.8	8	1.8
Increase research	-	0.0	-	0.0	3	2.1	2	5.0	3	5.2	8	1.8
Acquire political/ government support	-	0.0	1	2.4	2	1.4	-	0.0	-	0.0	3	0.6
Other	10	5.8	1	2.4	4	2.9	2	5.0	3	5.2	20	4.5
Total	(171)	38.2	(41)	9.2	(139)	310	(40)	8.9	(57)	12.7	(448)	100.0

* Respondents gave more than one reason.

An extensive number of reasons were given by students as strategies envisioned to improve the nursing profession (Table 23), such as to "*promote nursing in the media*," "*clarify the nursing role*," and "*increase professional attitude.*" Mentioned less often were to "*develop more effective nursing associations*" and "*provide more graduate programs*." Students generally intermixed both changes and strategies to indicate the same effect. According to the type of institution, the students saw two priorities—to "*promote nursing through media*" in the public sector and to "*increase professional attitude*" in the private sector. With respect to "*clarifying the nursing role*," the public students give it more relevance than did the private students. Again, students' perceptions of nursing as a profession and their strategies are similar according to the type of institution.

Table 23

Strategies Envisioned by Students to Enhance the Professional Status of Nurses

	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 89		n = 23		n = 57		n = 24		n = 28		n = 221*	
Strategies envisioned*	n	%	n	%	n	%	n	%	n	%	n	%
Promote nursing in the media	18	11.7	3	11.1	21	17.4	4	16.0	6	13.0	52	13.9
Clarify nursing role	12	7.8	3	11.1	25	20.6	1	4.0	4	8.7	45	12.1
Increase professional attitude of nurses	12	7.8	5	18.5	11	9.1	3	12.0	6	13.0	37	9.9
Increase more effectiveness of nursing association	15	9.7	1	3.7	7	5.8	5	20.0	5	10.7	33	8.8
Promote autonomy	11	7.1	2	7.4	10	8.2	3	12.0	-	0.0	26	6.9
Increase graduate programs	12	7.8	1	3.7	5	4.1	4	16.0	4	8.7	26	6.9

(table continues)

Strategies envisioned*	South				Centre				North			
	Public		Private		Public		Private		Public		Total	
	n = 89		n = 23		n = 57		n = 24		n = 28		n = 221*	
	n	%	n	%	n	%	n	%	n	%	n	%
Enact policies to support nursing	13	8.4	1	3.7	9	7.4	1	4.0	2	4.3	26	6.9
Change curriculum	5	3.2	1	3.7	7	5.8	1	4.0	3	6.5	17	4.6
Increase self-esteem in students	4	2.6	4	14.8	5	4.1	-	0.0	3	6.5	16	4.3
Increase support to students	6	3.9	1	3.7	3	2.5	1	4.0	3	6.5	14	3.8
Increase human approach	9	5.8	1	3.7	1	0.8	-	0.0	2	4.3	13	3.5
Improve connections	6	3.9	2	7.4	1	0.8	-	0.0	2	4.3	11	2.9
Better salaries	5	3.2	-	0.0	5	4.1	-	0.0	-	0.0	10	2.7
Enhance leadership	6	3.9	1	3.7	2	1.6	-	0.0	1	2.2	10	2.7
Enact evaluation of f. members	5	3.2	-	0.0	2	1.6	-	0.0	2	4.3	9	2.4
Accreditation	2	1.3	-	0.0	4	3.3	-	0.0	1	2.2	7	1.8
Increase training in university	3	1.9	-	0.0	1	0.8	1	4.0	-	0.0	5	1.3
Other	10	6.5	1	3.7	2	1.6	1	4.0	2	4.3	16	4.3
Total	(154)	41.3	(27)	7.2	(121)	32.4	(25)	6.7	(46)	12.3	(373)	100.0

* Respondents gave more than one reason.

Comparison of Faculty Members' and Students' Data

From the data collected from questionnaires administered to 57 faculty members and 221 students, it is possible to determine to what extent Chilean nursing students and nursing professors see nursing as a profession in Chile. The faculty members and students came from five universities—three public and two private—in three geographical regions. In the public universities, most of the respondents were faculty members and students from the South region. In the private universities, the respondents were mainly from the Centre region. Because it was a

convenience sample, with sample sizes varying across institutions, it is not possible to generalize with any confidence.

The profiles of faculty members in two types of institutions and three geographical regions who replied to the questionnaires are similar in terms of the dates that they received their degrees and the lengths of clinical practice. There are substantial differences in terms of the types of qualifications in nursing and other disciplines and in teaching experience. In the South, faculty members who responded had higher academic qualifications with master's degrees both in nursing and other disciplines, and the findings also revealed a greater variety of teaching experience compared to the other two geographical regions. Students' profiles were similar in both types of institutions; they shared attributes relating to age, satisfaction with nursing programs, reasons for being in nursing programs, and aspirations for future positions.

In terms of affiliation, half of the faculty members did not belong to the Chilean Nurses' Association or the Chilean Nursing Education Association. Most of the students did not belong to a nursing student association in their university. Many faculty members lacked interest in affiliation with a nurses' association in that they did not recognize the value of the association. Lack of affiliation with professional associations may be attributed in part to the fragmentation of the association after a law in 1982 made affiliation a choice rather than a requirement. There is still debate in the Chilean parliament on whether legislation to make membership in professional associations mandatory is desirable or not. The main reason that the students cited was a lack of awareness of these associations.

The majority of the faculty members and students viewed nursing as a profession. The faculty members gave as the main criteria for an association the need for theoretical and scientific knowledge, a response to specific needs, and the requirement for study in a university. Students gave basically the same criteria but placed them in a different order. With regard to definitions and criteria for a profession, the students were consistent in naming theoretical knowledge, a high level of education, and legal support as important. Legal support might have been identified so

frequently because nursing was included as an independent profession in the Chilean Legal Sanitary Code that was legislated in 1998. Therefore, students may have been socialized to an understanding of law as an important step in the recognition of nursing as a profession.

The main changes envisioned by faculty members related to more graduate programs, an enhanced professional image, and more communication with society. Students envisioned increased autonomy, better education of society through the media, and changes in professional attitudes. Faculty members believed that the best way to gain more autonomy is through a high level of preparation through graduate education. Students, however, viewed autonomy as an entity in itself. Both students and faculty members agreed on the desirability of an enhanced image, but students also saw the need to foster a professional attitude by nurses to increase the status of nursing as a profession. Internalization of the value of nursing as a profession may be as important as external recognition. The main strategies envisioned by faculty members were related to more professional development, more effective nursing associations, and more graduate programs. Students wanted to promote nursing in the media, to clarify the nursing role, and to have more effective nursing associations. Both faculty members and students perceived strengthening nursing associations as an important strategy, as well a mechanism for increasing the nursing image.

Faculty members added certain important strategies to enhance the professional status of nursing. Examples were to develop a strategic plan, to network nationally and internationally, and to enhance nursing's identity and visibility. Students referred to issues such as the importance of accreditation, more recognition and appreciation of new graduates, and the importance of eliminating nursing symbols such as caps and uniforms.

Gender

Male nurses, faculty members, and students comprised from 5% to 7% of the questionnaire respondents. There is a trend towards an increasing number of male students and faculty members with the creation of new job opportunities such as in emergency units, clinics,

trauma units, and a variety of emergent units. In the convenience sample, male faculty members were mainly from public universities and the South region, and male students were also similarly distributed. Male faculty members' profiles were similar to those of the total population. The number of males in the sample was insufficient for further analysis of findings. This may be an important area for further research.

Reflections on the Data from Educational Institutions

The data from faculty members and students generated a profile of the Chilean educational setting, but the data cannot be generalized because there was no random sampling. Each educational setting has had different realities in development and requirements; however, there are commonalities because faculty members do move from one institution to another, especially from public to private universities. Until the 1990s most nursing faculty members worked in public institutions. After this period the emergence of new nursing schools, especially in private universities, has created a competitive scene in which private universities select some faculty members from the public sector and others from the practice arena.

The profiles of faculty members in both sectors are similar in most respects; nevertheless, qualifications are different between the two sectors. Public universities have the more highly qualified faculty members. There is little information publicly available about faculty members, positions, salaries, and qualifications in both educational sectors. Students' profiles and visions of nursing are similar in both public and private educational institutions. The students emphasized the need for a legal framework to mandate nursing as a profession that requires university preparation as an important aspect, a point not raised by faculty members. The strategies needed to enhance the professional status of nurses that were selected by faculty members included more professional development and the creation of new programs, whereas students perceived a need for more autonomy in nursing practice. Both students and faculty members suggested improving

the nursing image through communication to society about what nurses do and fostering the development of stronger nursing associations.

In conclusion, suggestions from faculty members and students to improve nursing's image as a profession are as follows: increased affiliation of faculty members and students with professional nursing associations, more accreditation and development of nursing programs to ensure quality of education at a university level, increased autonomy in nursing practice, and the development of a marketing campaign to enhance nursing's image in society. Political action must also be considered.

CHAPTER 7:

A GLIMPSE INTO NURSING PRACTICE AND DEVELOPMENT IN CHILE

In this section the analysis of the data collected from 42 nurses from three public and three private hospitals in three different geographic locations and from 7 nurses in leadership positions in nursing associations and the Ministry of Health is presented. The findings provide a qualitative description of the differences and similarities between nurses in public and private hospitals and variations across the three geographic locations.

The findings are organized under five main headings. Nurses provided their perspectives of nursing in Chilean hospitals, the meaning of being a professional nurse in Chile, the extent of social and professional recognition of nurses in Chile, and the image of nurses in Chile. In addition, nurses in leadership positions in nursing associations and the Ministry of Health also provided their perspectives, and these findings are reported in a separate section of this chapter. A reflective passage concludes the presentation of the qualitative findings.

Most nurses who participated in interviews were in the practice setting and included managers (6), head nurses (6), and staff nurses (30) in six Chilean hospitals. Of the 42 hospital nurses interviewed, 37 were female and 5—all staff nurses—were male. All interviewees graduated from public universities. They had an average practical experience of 15 years. Five nurses had advanced preparation, with specialization in a particular nursing field. None had graduate degrees. Fourteen participants were affiliated with the nursing association and 10 with other associations or unions. The seven other participants came from the Chilean Nursing Association (CHNA), the Chilean Nursing Education Association (CHNEA), and the Ministry of Health (MOH). Nursing leaders were selected as participants because they were in key positions in these organizations. The leaders were highly qualified, with long careers in the practice or education field. Four of these nurses had graduate degrees.

I interviewed hospital nurses for two main reasons. The first was to explore their work in terms of how they chose their place of employment, their job satisfaction, the organizational structure in which they practised, their scope of practice, nursing identities, and the social barriers that they encountered. Second, I sought information about what it means to be a professional, how they saw the future of nursing, and what strategies were needed to reach that future. In addition, I interviewed nursing leaders to complement the data that I collected from nurses on their opinions of the main issues in nursing practice or education and to gather their views on the struggles that nurses face in trying to bring the profession to a more desirable status.

Description of Nursing in Chilean Hospitals

Public and private hospitals have had different development trajectories since the health reform of the 1980s. Public hospitals in Chile were disadvantaged by a lengthy period of reduced human and material resources, and these hospitals are still recovering from this period. In contrast, private hospitals constantly progressed in a political and economic environment favourable to their development. The mixed public-private health care system continues to evolve but still faces cycles of unstable conditions such as during the economic crisis in 2002.

Two main differences distinguish private hospitals from public hospitals. First, most of the main private hospitals are in the centre of the country where the wealthy population can be reached. Second, private hospitals are equipped with the latest technology available at a high cost to consumers.

In public hospitals the administration manages through a rigid hierarchical structure. In the field notes that I made of the three public hospitals, I described them as "*big, old-fashioned buildings, with many new areas and units added to the original structure*." These public hospitals have a confusing and complex bureaucracy through which services and care are provided to approximately one million inhabitants in each city of the sample. Personnel are affiliated with different unions, such as FEPROTEC, (Professional and Technician Health Workers

Association), FEPRUCH (Professional University Chilean Federation), and FENATS (National Health Workers Union).

The three private hospitals in this study differ from public hospitals with respect to resources, personnel, and the types of services provided. In my field notes I stated that the three private hospitals "*are new modern buildings, and have nicely decorated furniture, with more personnel and more technological advances, where the services are oriented to bringing satisfaction for the consumer.*" The first is located in the Centre and is the most sophisticated, utilizes more technology, and integrates new medical advances. There are more resources, better nurse-patient ratios, and a greater variety of health services. The second, which is located in the South, has a long tradition in the city of offering many health services to wealthy patients. The last, located in the North, is the only private hospital in the city, and consumers have access to partial health care services. Personnel in the three private hospitals did not belong to any union at the time of the interviews.

Organizational Structures

Depending on the structural organization of hospitals, nurses have different roles and responsibilities in their roles as managers, head nurses, and nursing staff. Neither public nor private hospitals have departments of nursing and therefore no nurse leader roles at the senior administrative level in terms of direct-line authority for nursing practice as distinct from other clinical practice. Nurse managers are responsible for management of personnel, resources, and systems of communication with nursing personnel. Researchers reported three types of structural organization in the public hospitals: (a) The nursing manager position is part of a subdepartment that is directly dependent on the medical department; (b) the manager has a more independent role in the organization, but there is no nursing department structure (managers fulfill a functional role). There is dependence on the director of the hospital, who has complete responsibility for the hospital; most hospital directors are physicians with some political involvement; (c) the manager is part of a group drawn from different units in the hospital, with the managerial staff acting as an

advisory group for the director of the hospital. Nurse managers participate and collaborate in 'decision making as part of the Executive Director Advisory Committee, but do not have full freedom in making independent decisions regarding nursing issues. As one manager said, ***"Our level of participation is good, but it could be better. We have a lot of participation in the medical sub department of the hospital."*** (*"Nuestro nivel de participación es bueno, claro podría ser mejor. Tenemos bastante participación en la subdirección médica del hospital."*)

In the private hospitals the nurse managers' philosophical point of view was perceived as "being in accordance with the views of patients and their families as "customers/consumers" who have to be treated well and fully satisfied in the hospitals because they pay. Nurse managers are responsible as "chief of the nursing personnel" and are expected to solve problems with physicians, patients, families, and nursing personnel. Congruent with public hospitals, there is no nursing department as an independent structure, but these private hospitals appear to be more flexible organizations and are more focused on efficiency. The structural organization is similar in the three private hospitals, where nurse managers are part of the managerial staff and report directly to the top manager of the hospitals, usually with one representative as part of the corporate leadership team. Labour conditions in private hospitals are unstable because nurses do not negotiate and unions are not allowed. Nurses can be fired at any time. Therefore, nurse managers constantly have to deal with issues related to management of business interests juxtaposed with nursing staff's struggles to increase salaries. For example, in the Centre and South private hospitals of the study, new nurse managers were not informed of the reasons that their predecessors had been fired. In the North, however, the private manager had been in the same position for a long time.

In the public hospitals managers are in charge of hiring nurses, but geographic differences were reported. The highest developed system of recruitment is located in the Centre and includes publishing notices in a newspaper or informal communication among nurses, which

the managers identified as ***"more useful and effective."*** Managers interview applicants together with the head nurse of a particular unit, and both nurses make the final selection decision. In the South the recruitment process appears less structured because of a greater supply of nurses. There is a mix of nurses, some of them highly qualified and other, newer graduates with lower qualifications and expertise. There is less recruitment in the North, where nurses are hired occasionally, mainly for temporary replacements (e.g., for pregnancy or sick leave). There are fewer opportunities, which leads to less job mobility.

The private hospitals differ from the public hospitals because they have, as one manager said, ***"a more rigorous recruitment system."*** For example, the Centre has general procedures for all personnel, and, if the manager supports the need for hiring, it is approved and the process starts. The procedure involves newspaper advertisements, personal interviews that include psychological tests, and, if the candidate is successful in the second phase, an interview with head nurses to decide who is finally hired. In the South the private hospital has a mix of procedures depending on specific units. In the North, in the only private hospital, there is no recruitment at all because there are only sporadic replacements.

Managers exercise discipline and evaluate nurses with the support of unit head nurses. In the public hospitals the procedures are not well developed or are currently in the process of development, even though there is a mandated evaluation standard. Once a year managers ask head nurses to evaluate their personnel. In general, procedures of recruitment, discipline, and evaluation are the domain of nurse managers and head nurses. Referring to evaluation, one manager noted, ***"The nurses we have in our institutions are docile and adaptable, although the young nurses are more rebellious than the older ones."*** In these cases, there are two options: Either the new nurse must adapt to the system, or the initial three-month contract is not renewed.

In the three private hospitals the managers have a system of evaluation and accreditation for all units and personnel, including nurses. In the Centre they have a permanent process of personnel evaluation and some developed standards. Nurses are evaluated by standards and

norms each month. In the South they are continually evaluated, but specifics differ from unit to unit. In the North the staff nurses have an oral evaluation each year because personnel are experienced and this is considered the easiest way to evaluate them.

Head nurses in the public and private sectors are the nurses who manage a unit of the hospital. They are in charge of managing and solving problems such as a lack of materials, changes in personnel, and a lack of human resources. They manage nurse activities and evaluate the nursing personnel. Head nurses depend on the heads of units, mainly physicians, who report to the central administration of the hospital on issues not directly related to nursing.

Nursing staff in both public and private hospitals report directly to the head nurse on issues such as shifts, performance evaluation, and education of patients. Management and decision making in the units are within the domain of the head of the unit. For example, the need for more nursing resources and personnel must be decided by the head nurses first and then agreed upon by the head of the unit. Nursing staff manage and evaluate nursing aides, who work with them directly and provide nursing care.

Human and Other Resources

Resources in the two types of hospitals are substantially different; the public health sector has fewer resources than the private sector. These include materials, personnel, systems of communication, and technological advances. In terms of human resources, there is a bigger difference in the number of nurses per bed between public and private hospitals than there is among the three geographic locations represented by the hospitals included in this study. For example, in public hospital medical units the average ratio of nurses per bed is 1:20, whereas in private hospitals it is 1:10. Moreover, in units with less specialized nursing services or on night shifts, nurses are responsible for more than twice as many beds in the public hospitals as they are in the private hospitals. These differences are complex and related to other elements such as who is in charge of work, nursing aide supplies, and the quality of care offered. By geographic location, the most adequate nurse-patient ratio in public hospitals is in the Centre, then in the

South, and, last, in the North. In the private sector the three locations have similar ratios of beds per nurse.

Perceptions of the quality of nursing care vary. For example, in the Centre in both public and private hospitals, nurses reported that they offer good quality of care. In the Centre, public hospital nursing staff reported excellent team work, prepared personnel, and good patient-outcome indicators. The manager asserted, ***"We have a good quality of care; perhaps it is perfectible or it can be better."*** When probed for more details, managers and head nurses agreed that they provide a good quality of care, but it is not optimal mainly because of a lack of standards and personnel, but not of material resources. In contrast, in the private hospital at the Centre, the manager stated:

> ***Labour conditions here are really good. For example, we have a good level of nurses working here; we have material resources and everything! We have a distribution of personnel according to workload and complexity. And if we have a need for more human resources, then we do hire.***

The nurses are conscious of the strategies being used to maintain standards, such as patient satisfaction surveys, records of nursing process, promotion of holistic care, norms and procedures that are constantly checked, and resources such as personnel, technology, supplies, and accreditation. One nurse noted, ***"If we make a mistake, then, immediately it is reported. Moreover, we have meetings, discussions to solve the problems."*** Nurses in the Centre, in both private and public hospitals, pursue a similar goal of improving quality of care.

The perception of the quality of care is not consistent in the North and South in both public and private hospitals, where nursing staff have a divided opinion. Some nursing staff felt that they are not providing good quality care because ***"we have too much work, we don't have good records, we do not set standards of quality, and often we do not have a nursing plan."*** Another nurse validated that ***"we give a good quality of care because we have some registers, nursing notes, charts, and indicators of patient satisfaction."*** In both these public and private

hospitals, nurses perceived a lack of personnel and time, which creates a situation in which nurses feel overworked.

Choice of Job

Differences in the two types of systems were noted when nurses look for hospital positions. In selecting positions they are motivated by a variety of factors. In the public hospitals, the managers who are in charge of the hiring process confirmed that nurses have different motivations: (a) Nurses sometimes move from one city to another in search of a location that offers more professional challenges and better salaries; (b) the relocation of husbands, in the case of married nurses, is an important factor; and (c) nurses relocate to obtain a more prestigious or higher position. In contrast, in the private hospitals there was the perception that nurses decide to move, first, for more professional challenges and to be recognized as experts; second, because of family-member relocation; and third, because they like to work in the private sector and therefore leave public-sector jobs. In both types of institutions the nurses believed that Santiago, the capital, is the best place for opportunities. The nurses in general agreed that career development in nursing practice and the opportunity to improve their career are more likely to be associated with moving to assume managerial roles than with opportunities to increase qualifications or expertise. The nurses expressed the desire to be rewarded with better salaries. Being a staff nurse is considered a flat progression that leaves little room for career advancement.

In general, the vision of nursing staff was that they remain in the same position forever and that expertise in clinical nursing is valued in promotions to management positions. Such recognition, however, is not within their expectations. Nurses tend to move to hospitals with greater career mobility opportunities and the consequent higher salary potential, new and better labour relation environments, and more availability of continuing education. Different expectations among nurses are related to two different values: One group believed that nurses in the public sector can achieve greater career development and ascendant positions, and the other group believed that nurses in the private sector have more prestige and access to technological

advances. As one nurse manager commented, ***"It is not the salary which attracts nurses to the private sector, but surely it is the prestige and other benefits such as meals, uniforms, and bonuses."*** (*"No es el salario que atrae a las enfermeras al sector privado, sino que es el prestigio y otros beneficios tales como alimentación, vestuario, y bonificaciones."*)

Satisfaction in the Position

The reasons for satisfaction with nursing positions are varied. In both health sectors the managers are the highest authority who represent professional nurses and nursing personnel. In their responsibilities they manage not only personnel, but also general resources for nursing staff. The managers in the public sector are satisfied because reaching this position is a valuable recognition of their performance. In the private sector the managers are in these positions because they accept the entrepreneurial philosophy in the hospitals, but they are less satisfied because they feel more responsibilities on their shoulders and they know that attaining this position did not depend on their "expert knowledge in nursing," but rather on their abilities with "power and management." For example, one manager explained, ***"Here they say we are all workers and we are multifunctional; if you don't like it, the door is open."***

Head nurses in the public sector are in charge of managing and solving problems in the unit such as a lack of materials, the movement of nursing resources, the shift changes of nursing personnel, and conflict between institutional policies and units' personnel demands. Head nurses in that health sector, however, complained about the extensive mixed work that they are expected to complete. They have to deal with conflict with patients and families, and management of their units demands skills in communication and human relations. One head nurse from a public hospital observed, ***"Our business is related to solving problems due to a lack of resources, lack of personnel, communication with physicians and following their indications, seeing workload, and distribution of personnel."*** In contrast, head nurses in the private sector do more clear administrative or management work, with less involvement in human conflicts and more availability of resources. One head nurse from a private hospital noted, ***"But different from***

public hospitals, we make better decisions because we have a good structure and we have material resources." Management of units in private hospitals appears less complex, less stressful, and more relaxing than management of units in the public hospitals.

Nursing staff in both public and private health sectors who were happy with their positions noted that there is a relationship between nurses' preference for working with patients in units such as pediatrics, ICU, or surgery and job satisfaction because they choose work in places with more caregiving and contact with patients. Nursing staff found satisfaction in practice because it allowed them to be ***"closer to patients, to give them care and keep ourselves in touch with patients, and to be witness to the recovery and healing of patients."*** The reasons stated by nurses who are not satisfied in their nursing positions varied in the three geographic locations of the three public hospitals. They identified a lack of recognition for nursing care from the families of patients, the physicians, and personnel. Nurses in the public health sector complained that communication problems are related to a lack of resources, especially in the number of nurses and nursing aides for the number of beds. In the private hospitals, however, nurses gave three different reasons. First, in the North, the nurses reported conflicting values between institutional policies and patients' needs for nursing care. In the private institutions instructions given to personnel are not always well accepted by nurses, who felt that their responsibilities are not always understood as directly benefiting the patients. But as one nurse mentioned, ***"It is an entrepreneurial point of view."*** Second, in the Centre private hospital, the nurses described social-class conflict with families of high status or class who make demands for services from nurses but do not recognize nursing roles and responsibilities. Third, in the South private hospital, the nurses discussed communication problems with physicians and the families of patients and felt that working in the private sector is more complicated. As one nurse noted, ***"We do things with more responsibilities with a lack of our own autonomy. It is not grateful work because families who pay are more demanding."*** Therefore, institutional and nursing struggles coexist in the North and South private hospitals, which produces conflict within the nursing staff and the

perception of a lack of autonomy to make decisions of benefit to patients. The nurses mentioned a lack of authority related to emerging activities that they have to do, such as business and economic management, including such things as maintaining registers of payments, calculations relating to physicians' activities, and charges for services.

Scope of Nursing Practice

Nurses' roles differ in their scope of practice between public and private hospitals. Nurses remarked on the differences in everyday duties such as being responsible for nursing care and managing personnel. In the hospitals in the North and South, both public and private, and in the Centre public, nursing routines in the units were described similarly as including receiving patients' information, visiting patients, preparing nursing plans, completing physical exams and laboratory procedures, educating families, updating prescriptions, managing personnel, and scheduling rotations. Some nurses complained that ***"we make decisions about patients' evolution, procedures, prescription changes, practically everything, when the physician comes to visit the patients. However, we do more perhaps of what physicians should do!"***

In the Centre private hospital, there is a clear separation of nursing and medical roles. Nurses make decisions for all patients with respect to care, such as working on patients' plans, listing priorities, noting whether duties are being fulfilled, delegating work to nursing aides, and planning activities related to nursing care. Medical decisions are made exclusively by physicians who spend their time with patients in the units, and the nurses' role is related more to nursing care.

These role differences are created because nurses, with the exception of those in the Centre private hospital, perceive themselves as assuming medical roles, including decisions relating to whether to reduce or increase doses of therapies and prescriptions and to continue or stop medical procedures. The nursing staff know that assuming such roles is illegal and not appropriate, but they nevertheless continue because physicians are too busy or not available.

Hence the nursing staff feel forced to take on the responsibilities of medical staff and then delegate nursing care to aides.

Employment Conditions

In terms of satisfaction with their careers, nurses who work in the public health sector have been encountering difficulties in progressing from Grade 18 to top positions below Grade 10 because of a law. (Career progression in the public health care system depends on the number of years of education; the levels are from 1, the highest, to 30, the lowest. They were modified in the 1980s.) Nurses who have worked in the public sector for many years cannot advance in their positions as can other professionals. In the private health sector career progression is related to entrepreneurial policies and market factors, but it is not regulated in terms of the levels to which nurses can aspire in their careers.

The nurses in general, no matter the sector or place of employment, agreed that there is dissatisfaction with employment conditions and salaries. In the public hospitals the nurses explained that there are incentives to keep good or highly qualified nurses, but retention of sufficient nurses is difficult because of a lack of positions. Public hospitals have a system of education for nurses such as "training courses" in the hospitals, although the nurses may have to pay fees and expenses. Nursing staff may also need to reschedule shifts, find other nurses to replace them, or take courses while on vacation or during free time. In addition, the nurses felt that they cannot find an adequate range of relevant courses when they need them.

Private hospitals use marketing approaches to motivate nurses to apply for positions in their institutions. Salaries, however, are similar in both health care systems, and nurses in general are not satisfied with their incomes. Moreover, the nurses in private hospitals disclosed higher levels of dissatisfaction with salaries and career progression related to salary increases. Nurses in private hospitals have benefits, which buffer their desire to move to another place; for example, they may have more educational upgrading opportunities and benefits such as fee payments for courses, scholarships to visit foreign nursing units, free uniforms, free meals, and shift flexibility.

Benefits in public hospitals are less evident; however, they do boast free day care, free health insurance, and access to loans. In the public hospitals, nurses who are awarded positions can have a stable career through the system and advance through the years. Although advances for nurses in the public health sector are limited by economic resources, the situation is similar for other professional health workers (with the exception of physicians, dentists, and pharmacists). The nurses demanded more graduate programs, but at the same time they realized that courses are expensive and that many cannot afford them.

Geographic factors affect the opportunities to develop and acquire more knowledge. Universities and other courses or programs are more concentrated in the Centre, although some are available in the South, but fewer in the North. The course and program requirements include full-time enrolment on campus, with most nurses having to travel and pay fees. There is a lack of financial support through scholarship programs and loans for education. There is little difference between the private and public institutions in terms of the types of courses or programs that nurses would like to attend. The nurses in private hospitals valued clinical expertise because they are in a system that determines merit based on specialization; however, enhanced expertise does not translate into better salaries. In both cases nurses pursue higher education as a personal challenge rather than as an employment plan. Some courses are recognized for selection in advancement to a management position. Because there may be no career benefit, there is often lack of motivation to pursue intellectual development. Therefore, nurses, mainly managers and head nurses, have taken a variety of certificate courses in the areas of management, quality care, and administration.

All of the nurses interviewed agreed that labour conditions must improve. They wanted more recognition through better salaries, clarification of nursing roles in the health team, and more equality and better rapport with physicians. The nurses also wanted more access to graduate programs, more opportunities for professional nursing development, and more satisfying working

conditions. Substantial differences between public and private hospitals were found in terms of benefits, flexibility, and professional development opportunities.

Similarities and Differences Between Nursing in the Public and Private Health Care Sectors

With regard to the organization, resourcing, and working conditions of nurses in public and private hospitals, three main issues emerged: (a) In both public and private hospitals, there is a lack of nursing departments with responsibility for nurses and nursing issues under a nursing structure, (b) the lack of nurses in public hospitals was perceived to adversely affect the quality of nursing care and the conditions under which nurses practice, and (c) there is a lack of clarification of roles in both public and private hospitals. In the public hospitals there is a blurring of nursing and medical responsibilities, and in the private hospitals there is a constant struggle between entrepreneurial-business demands and nursing roles and responsibilities. Moreover, private hospitals lack unions and collective bargaining power.

What It Means to Be a Professional Nurse in the Opinion of Practising Nurses in Chile

Nurses from public and private hospitals explained why they considered nurses to be professionals and provided comments in three areas: affiliation with the Chilean Nursing Association, recommendations for changes, and strategies envisioned for moving the profession of nursing forward.

Conceptualization of Being Professionals

When considering nursing as a profession, managers in the public hospitals identified three main factors: autonomy, knowledge, and university-level education. One manager believed that ***"nursing is a profession because nurses are capable of working autonomously; it means applying the nursing process, and then to use personnel adequately, whether nurses, nursing aides, and also other resources."*** (*"Enfermería es una profesión porque es capaz de trabajar*

autónomamente, significa aplicar el proceso de enfermería, y entonces usar el personal adecuadamente, ósea a las enfermeras, a las auxiliares de enfermería y los recursos.") Another manager cited factors such as ***"knowledge, recognition by society, personal abilities and skills, scientific and humanistic knowledge, updating knowledge and specialization in something."*** (*"Conocimientos, reconocimiento por la sociedad, habilidades y destreza, conocimiento científico y humanista, actualización y especialización en algo."*) A manager in a private hospital argued that ***"nurses work as experts with knowledge and responsibilities."*** Other managers mentioned service orientation, ethical principles, and the existence of a system of continuing education.

Head nurses in the public sector listed a variety of factors for considering nursing a profession. One head nurse suggested ***"knowledge applied to practice, university level of education, and values."*** Another head nurse added that the preparation of nurses includes decision making, judgment, common sense, and ethics. In private hospitals the head nurses concurred that nursing is a profession, as one head nurse stated, ***"because of scientific and humanistic education, the university level of education, a higher cultural and social status, and specialization."*** Another head nurse referred to the expertise, ***"which includes not only personal, technical, and own knowledge, but also continuing education and assertiveness."***

Nursing staff in the public sector declared that nursing is a profession because of knowledge (scientific or theoretical), university-level education, the match with criteria used to define *profession*, skills in social issues, empathy and abilities in interpersonal relationships, service to others, and values as embodied in a code of ethics. Staff nurses in the public sector identified nursing as a profession because of ***"the knowledge, the theoretical bases applied to practice, the university level, the leadership, and the Ethics"***; ***"the criteria of responsibilities such as intelligence, the use of criteria, judgments, and intuition"***; ***"a universal vision, not like technicians who are more limited. Professionals have a wider field of participation in politics***

and the social arena"; and ***"a high level of preparation, the expectation to make decisions, knowledge and skills, and the focus on human beings."***

Nursing staff in the private sector voiced similar reasons for supporting the definition of nursing as a profession: Knowledge, humanistic preparation, and expertise were major defining points. As one nurse noted, as a professional she ***"has skills, sensitivity, and the respect as a professional."*** (*"La enfermera tiene habilidades, sensibilidad y el respeto como profesional."*) One nurse shared the same perception as nurses in the public sector that nursing is a profession because of ***"knowledge, scientific method, the creative part of each person, the university level, ethics, continuing education, the leadership attitude, and the ability to apply knowledge in practice."*** Another nurse added ***"But do things well!"*** to emphasize that maintaining high standards is key to professional status.

However, differences in perceptions of what it means for nursing to be considered a profession were also found. Some groups of nurses conceptualized professions in relation to providing service to others, such as those that are humanistic, with holistic criteria; whereas others conceptualized professions in relation to requiring a high level of preparation as professionals as experts. The former conceptualization appears to be more marked in the public hospitals and the latter in the private hospitals, but further investigation would be needed with a larger sample size to make a definite statement.

Affiliation with the Chilean Nurses Association

Nurses' affiliation with nursing associations differed according to geographic location and between public and private health sectors. Managers and head nurses in the public hospitals who were interviewed were all affiliated with the CHNC, but none of the nurses interviewed participated in activities, meetings, or resolutions. On the other hand, managers and head nurses in private hospitals had all been affiliated with the CHNC at some point in their professional careers, but no longer were. Most staff nurses in both health sectors were not affiliated, with the only difference occurring in one public hospital, where all of the nurses interviewed were

affiliated. Their reasons for choosing whether or not to be affiliated varied, and each group will be discussed.

Managers in the public sector were affiliated but did not participate because they did not agree with the aims and objectives of the CHNC. One nurse contended, ***"The CHNC is too political; that is not attractive for us!"*** They agreed that there is a lack of motivation for nurses to participate; thus, few were affiliated. Managers in public hospitals agreed that a nursing association with little affiliation and participation is not really a strong organization. One manager commented, ***"I don't know if I must change, or the CHNC!"*** Managers in the private hospitals reported dropping their professional association affiliation when they moved from the public to the private health sector. They strongly disagreed with the CHNC and believed that it is not a strong and successful association because, as one nurse complained, ***"I believe that the last thing CHNC has done is to concern itself with the profession."***

The head nurses in public hospitals were all affiliated with the CHNC. They knew that its purpose is to support nurses and the profession; however, they described the CHNC as an organization of ***"older people. One doesn't see action, and there is a need for more active nurses. There is no motivation to be affiliated."*** The head nurses recognized that many years ago, when CHNC was active and held regular meetings, nurses participated more. However, one head nurse noted, ***"Now we have a chapter of the CHNC, but nurses do not participate, only the executive."*** Moreover, another head nurse added, ***"there is a lack of better distribution of power between main actors and the rest of nurses. Power is not in people, but in those who make decisions. Yes, there is a structural problem in CHNC."*** The head nurses in the private hospitals were not affiliated with the CHNC because it is ***"backward."***

Regarding nursing staff in general, the level of affiliation varies more with the type of institution rather than with geography. For example, in one public hospital the nurses were partially affiliated, in the second they were not affiliated, but in the third all of the nurses were affiliated. In the private hospitals the nursing staff were not affiliated; however, they wished to

become affiliated. Nursing staff who were not affiliated often knew the purpose of the CHNC. As one nurse declared, ***"It is to support professional practice, represent us with authorities, and keep track of memberships to improve benefits and salaries"***; however, the same nurse said, ***"Yes, I have had the opportunity to be registered, but I don't know if it is important in my life."*** The nurses knew that the CHNC provides some cohesion and legal support to the profession. But, at the same time, they saw the CHNC as ***"boring, archaic, which doesn't motivate you, and the lack of power as an organization."*** One nurse noted, ***"Maybe I am lazy; also I don't have much time, but I do not see advantages to being in a chapter of the CHNC."*** Other nurses did not know the purpose but felt that it is not a successful organization because it is distant. According to one nurse, ***"The CHNC is a group of old-fashioned nurses, and they differ with our interests."*** Although many nurses knew and clearly understood the CHNC's roles—***"to solve our problems, improve professional development, provide legal advice, meet, and share experiences"***—they did not like the political involvement of the CHNC. One nurse complained:

> ***That is the main reason that I am not a member of the CHNC. It doesn't satisfy our purpose, because the CHNC does many things, but they don't solve; they are not there for us; they leave us on our own, abandoned.***

A group of staff nurses suggested that the CHNC is not a successful organization ***"because it is very political, and the CHNC has an outdated organizational structure."*** For example, nurses protested that the main members of the CHNC are in the executive and do not listen sufficiently to all nurses. They criticized the CHNA's lack of communication, which results in limited membership. Moreover, the nurses did not trust the association. One nurse accused, ***"Each member of the CHNC tries to use or get something out of us."*** The nurses lack motivation to become affiliated with the CHNC and felt that they needed something to attract them to become members. They did not think of membership as a right or an obligation.

The nurses' criticism of the CHNC was strong, and they believed that the association is not interested in attracting more members. There seems to be a lack of connection between

CHNC and the practice of nursing in the hospitals. One nurse lamented, ***"I don't see that CHNC motivates colleagues. If I have seen the president occasionally or members of the CHNC to support or encourage us, I cannot say for sure to have seen them."*** There are few meetings, and information is not regularly updated. As one nurse complained, ***"I don't have any information about them. I don't know how they work. I don't know anything about the Sanitary Code or autonomy in provision of nursing care, or access to benefits."***

I attended one regional nursing association meeting with a group of potentially 100 nurses in a main hospital who were affiliated and observed that

> ***there were around 20 nurses who were arriving one by one; they were silently waiting for news as the president spoke. There was no discussion or exchange of ideas among nurses; it was a passive and low debate. The lack of motivation of nurses was notable, and they were waiting passively for information or suggestion to follow an instruction.***

The nurses who were interviewed were not active participants in their professional organization, which results in apathy to issues concerning the development of nursing as an organized profession. Moreover, it seems that nurses do not realize the connection between affiliation and the development of a strong and collective professional identity.

Recommendations for Changes

In the interviews the nurses offered different suggestions on the process of developing professional nursing strength. Managers shared the view that professional nurses need to become more active politically. As one said, ***"We need more nurses as politicians and leaders such as mayors, senators, parliamentary members, deputies, or ministers, with a stronger image."*** Some head nurses also had seen the CHNC perform positive acts, such as enacting the Sanitary Code Law, improving salaries in emergency units, and providing legal support. Staff nurses also saw some positives, such as the inclusion and visibility of nurses in the Sanitary Code Law and more economic benefits in some units and hospitals. The nursing staff in public hospitals wanted the CHNC to become more visible: ***"a CHNC that allows us more access to journals, assistance***

to attend a congress coordinated by the CHNC, and a CHNC campaign to better support graduates' education with more development of leadership opportunities."

In the private hospitals the nursing staff wanted to see the CHNC as a strong, united organization that is available for nurses; but their perception was that it is focused only on political and negative aspects such as strikes or protests. On one hand, the perception was that political activism is wrong; but on the other hand, when the nurses compared CHNC with other associations, they made contradictory comments: ***"The medical association is really strong. They are not only politically involved, but they also defend their members. They show up, protest, and negotiate if they don't have salaries they like; and they present positive ideas."*** The nurses wanted the CHNC to have a stronger public voice. One nurse claimed, ***"We must be more aggressive, with better leaders, with a good basis of support, and not just the political activism alone."***

Therefore, the nurses perceived that the nursing association has a low profile because of its low membership, a focus on political involvement that most often is reactive to emergency conflicts, a lack of communication with potential constituents, and an old-fashioned, hierarchical organizational structure. There seems to be a tension between the perception that more political involvement is needed and the perception that perhaps the association is too politically oriented. As a result, nurses have been passive, which has created indifference and a lack of interest in forming an active collective identity.

Strategies Envisioned for Moving the Profession of Nursing Forward

The nurses offered a variety of suggestions to increase their professional status; they can be divided into external and internal categories that include changes within society and changes within nurses themselves. Managers and head nurses suggested a variety of changes to stimulate professional development, such as ***"more professionalism, more attendance as a group, do research and publish and thus have a more scientific aspect that promotes a better image and profile of nursing as a profession."*** In the public health sector the nurses suggested different

causes of the problem. On one hand, the nurses proposed that more criteria be used in the selection of students for nursing programs, because, currently, many students are studying nursing because they cannot afford other programs. On the other hand, the nurses in the private hospitals suggested the need to present a more professional attitude to improve nurses' image. One nurse explained:

> ***We have to change our preparation for a more professional attitude! We have to educate society, teach them who really is in charge of their care. First, we have to identify ourselves to patients to be more visible and clarify our roles in practice. Also, physicians have to work in a team and accept their mistakes, and not just come to sign papers. We are equal professionals.***

Therefore, nursing managers and head nurses saw a range of factors in education and practice that foster a change in nurses' attitudes from the inside as individuals and collectively as a group.

Nursing staff in both health sectors also saw the need for both external and internal change; however, some of them advocated for more radical changes. In the public hospitals external changes that nurses mentioned included a need for radical change or reengineering, because the hospitals are old structures with a variety of human conflicts. As one public hospital nurse said, ***"This hospital is a feudal castle, with rules and a different work system in each unit."*** The nurses saw ways to change the image internally, such as having more public distribution of professional nursing roles. They felt that these changes must include an increased level of preparation of professional nurses, including graduate programs, with more humanist perspectives. The nurses suggested that the restructuring of the curricula must include courses on leadership that foster higher self-esteem in students and more coordination between education and practice sectors. One group believed that there is a need for more leaders. In the private hospitals the nurses saw the need for more preparation in management and research skills and more opportunities for education and upgrading. One nurse concluded, ***"We need more master's and specialized programs, a change in attitude of nurses, more familiarity with advances in technology, and to increase awareness of political and societal changes."*** Some participants

believed that nurses themselves have to change because they need to be concerned with what is needed by nurses today, including a less servile or submissive attitude.

A summary of the nurses' suggestions for changes to improve the image of nursing as a profession include, first, that the changes must come from nurses themselves, such as better degrees, attitudinal changes, greater political involvement, and effective leadership; and, second, that the changes must come from outside the institutions, with financial and social recognition, clarification of roles, a better public image, and a strong nursing association.

Similarities and Differences

Nurses' internal sense of professional identity in terms of their conceptualization of nursing as a profession was fully affirmed. Three main concepts arose in the interviews: knowledge, university education at the baccalaureate level, and humanistic values. Concepts of autonomy and self-determination were not explicitly stated, with the exception of one manager. With regard to affiliation in the CHNC, there was little active interest, with many nurses voicing a poor opinion of the CHNC. Consequently, most of the nurses interviewed do not see themselves as part of the collective group. There is a substantial difference in this respect between public and private hospitals: Nurses in the private hospitals were less affiliated and motivated to participate in the professional nursing association. The nurses proposed that more nurses become affiliated with CHNC and promoted political involvement in a positive way. The strategies suggested to improve the professional development of nurses focused on more graduate programs and strengthening of the CHNC as vital components of the revolution in nurses' attitudes to advance nursing as a profession in Chile.

Social and Professional Recognition of Nurses in Chile

Nurses who worked in the hospitals in both types of institutions, public and private, offered their opinions about the three sources of recognition that they feel are important: society,

physicians, and peers. There were no differences among the nurses from the three geographic locations. However, some differences were found between the public and private health sectors.

Recognition by Society

Within the health care system, workers acknowledge the power and hierarchical structures of nursing, but members of the community are not always aware of the different levels of nursing. Managers in both public and private hospitals agreed that nurses do not have as clear a role in society as they had a long time ago: ***"We had it and lost it."*** Specifically, the managers noted that there is a confusion of roles between professional nurses and nursing aides, but they acknowledged that people in the hospital system perhaps realize who is a professional nurse when they refer to nurses as ***"the boss of the unit."*** Head nurses also believed that nurses do not have a good position in society because ***"society does not identify nurses as professionals."*** In public hospitals head nurses are seen as ***"the boss,"*** whereas in the private hospitals they have more social conflict in their roles. One head nurse in the private hospital complained, ***"Families believe that we are nannies of the unit. In the private sector they complain a lot, and the only thing they ask is 'What is your name?' with a lack of respect!"*** Therefore, in the public hospitals, because of the hierarchically structured organization, managers and head nurses are identified as "the boss," whereas in the private hospitals nurses are seen as providers of the services expected by an elite class.

The nurses had similar opinions that the profession does not have a proper place in society, one characterized by ***"greater respect and status with better salaries,"*** and that there is a confusion of roles in practice between nurses and nursing aides. They agreed that few people recognize nurses as professionals, and in hospitals people do not recognize nurses' skills. One staff nurse contended that nurses are identified as ***"whatever person who uses a white uniform."*** Nurses in Chile have worn blue sweaters and white uniforms as a way to distinguish them from nursing aides; however, the nursing staff in private hospitals felt that society cannot distinguish them by uniforms. The nurses believed that they are invisible because they are ***"confused with***

nannies or caregivers." One staff nurse discussed the reasons for that confusion: ***"We nurses work very hard but are invisible, too quiet, and we do not get involved in public affairs."***

In general, the participants saw their positions as professionals in society as not as highly valued as they would like. Therefore, they were not satisfied with their status in society and believed that they do not have the same status recognition that other professions do, such as engineers, lawyers, or physicians. All of the nurses in both the public and private sectors agreed that they would like nursing care to be recognized as valuable work in hospitals and that they would like to clarify the role of professional nursing. They desire more visibility and voice as professionals.

Recognition by Physicians

All of the nurses interviewed agreed that they have lower status and value than physicians. They believed that society reinforces nurses' disturbing relationships with physicians because ***"Chilean society believes that nurses are followers of physicians' orders."*** (*"La sociedad Chilena cree que las enfermeras somos seguidoras de las indicaciones de los médicos."*) Moreover, the nurses felt that society also sees physicians as ***"having an absolute truth"*** and then accepts them as a superior authority. Concomitantly, physicians often do not accept contradiction to their opinions. Many nurses protested that physicians also believe that nurses are there only to help them. According to one nurse, ***"Physicians are seen as semi gods. [You] think that they are male and make mistakes, but you, as a nurse, are just there only to remind them, make suggestions, and nothing else."*** Moreover, the nurses complained that many physicians think that it is acceptable to offend nurses and that they sometimes treat nurses rudely. One nurse said, ***"Physicians can increase their tone of voice, argue with you, but it is impossible for us to reply because anything can be used against you, and you have a conflict or go mad."*** Therefore, role and gender conflict and social hierarchy between physicians and nurses have made nursing an invisible profession. Physicians do not recognize nurses as professionals,

and societal stereotypes of nurses as docile women who receive instructions and support physicians have contributed to an unbalanced power relationship between nurses and physicians.

Recognition by Peers

In terms of relationships with other nurses, the participants agreed that there are two generations of nurses, older and younger, often with a 20-year gap in age. For reasons that will be discussed in the next chapter, few nurses who were interviewed are in the "middle" generation, which is likely a reflection of a "lost" generation of nurses in Chile. The older-generation nurses tend to be docile, whereas the younger generation is more aggressive. Some of the older nurses have good impressions of young nurses, and they pointed out that new graduates are not submissive or compliant. One older-generation nurse commented, ***"Our preparation was terrible because our instructors put physicians in a higher level than nursing students; however, they said that we were an elite group because we have knowledge, but in reality one sees that it isn't that way."*** Another described their nursing education as making nurses ***"too docile, . . . but new graduates have a different attitude, are more aggressive, more questioning, argue everything. . . . I think they are extremely radical."*** However, in terms of human values in nursing education, the older nurses believed that new graduates lack values and motivation in professional issues. Positively, in the opinion of some of the older nurses, new graduates are more resistant to receiving orders. As one nurse asserted, "***They can say immediately when something is wrong and solve it, whatever it is***."

Similarities and Differences

The nurses acknowledged a lack of recognition from society and physicians, as well as conflict with colleagues. They realized that they do not have as high a position in society as they would like because, as they said, society does not have knowledge about professional nursing care. The nurses explained that society assumes that nurses in hospitals are helpers of physicians but not persons with knowledge and skills that contribute to their care and health. Physicians, in a

more traditional male profession, are the main health co-workers of nurses and were viewed by some nurses as abusive and not professional. Nurses' criticism of physicians is a highly contentious issue, and the nurses may feel powerless in addressing it. Their peers are divided into two groups by age, with differences in values that can lead to conflict in terms of perceptions of roles and appropriate behaviour. In the private sector the nurses seemed more concerned about recognition in terms of professional status by families and patients and less concerned about age differences among nursing staff.

It is difficult for nurses to develop a cohesive nursing identity with a lack of recognition from society, physicians, and some nurses; and this inhibits nurses from assuming a more independent role. The participants were concerned that consequences of this lack of recognition include undervaluing of nursing care, conflict related to power relationships with colleagues and physicians in health care organizations, and lack of respect from families and patients, particularly in the private institutions.

Image of Nurses in Chile

In the last two decades amidst economic and political changes, Chilean society also underwent changes in terms of social relations of individuals and groups. Nurses as a professional group have a place in society, and how they are positioned will be discussed using categories of professional hierarchy, social class and elite society, chauvinism and machismo, discrimination by gender, racism and xenophobia, and image associated with physical appearance.

Professional Hierarchy in Institutions

The participants perceived nurses' conflict as relating to position within hierarchies in health organizations such as hospitals. The professional nurse is located in the "middle" between nursing aides and physicians. This position does not help nurses to become recognized in terms of their intellectual knowledge and specific skills because they are undervalued, especially by physicians. Many physicians treat nurses and nursing aides similarly: as though they are there just

to receive orders or to follow their prescriptions. Physicians expect to control both care and cure. There are additional conflicts between nurses and medical students and new medical graduates who often demonstrate little respect for professional nurses. As one nurse mentioned, ***"New graduates in medicine believe we are their servants and that we are there to satisfy their own needs."***

The nurses saw themselves as similar to midwives, physiotherapists, and occupational therapists (health professionals who by law have the same status). Nurses, however, are closer to patient care in that they provide continuity of care within hospitals. Patients and families do not realize who is in charge and has authority and responsibility for providing round-the-clock care, and the nurses felt a great deal of frustration. As one nurse noted, ***"That means our work is not valued. We are with patients 24 hours, and we do many things."*** Institutions, mainly in the private health care sector, ***"do not collaborate on this issue of giving support to us nurses."*** Institutions' orientation is more focused on ensuring satisfaction to patients, families, and physicians, in that order, because they are market oriented. At the same time there is a perception that institutional administrators see all nursing personnel as one entity, without differentiating variations in qualifications.

Therefore, the nurses identified an imbalance of authority and respect with physicians and others in hospitals, and they demanded ***"more respect from physicians."*** They also acknowledged that they need to take more power for themselves, because some nurses perpetuate oppressive behaviour or exhibit low levels of self-esteem. As one nurse remarked, ***"There are places where nurses accept what physicians say and that they do not appear to be as professionals with competencies and a clear role. In some units nurses do not appear to make decisions about anything!"***

Social Class and Elite Society

In terms of social class and positions in society, the nurses realized that they are a middle-class profession and that they are living in a society with class struggles that cause

barriers. One nurse described nursing as ***"lower than architects, lawyers, and physicians."*** Another nurse emphasized, ***"We live in a consumer society. That means we live in a market society, that everything has a price. Moreover, it is a competitive society."*** Another complained, ***"We are a middle-class profession, and for nurses this is bad, because people think that being a nurse is degrading. We also live in a conformist society: We nurses do not have much ambition; therefore we do our duties and that's all."*** Socioeconomic factors such as salaries and the culture of Chilean society are also barriers: ***"Personally, I want to study more, but it is very expensive, and I have a family to care for and support."***

The nurses interviewed suggested that Chilean society moves forward because of money, prestige, and success. One nurse noted, ***"There is a lack of ethical values in terms of competition to have a better social class position because we Chileans live in a society of supply and demand"*** as a marketing ideology, where profit is the most valuable outcome. Nurses struggle with the interplay between social class and elitism, particularly in the private health sector. As one nurse recognized:

> ***I work in the private sector, where people of high-level income come, and they always look at us as if we are caregivers or nannies. I am small, darker skinned. I do my procedures, and they say, "Hmmm, look at this little one, eh? She is good!" . . . with a lack of respect toward you as a professional.***

There is a relationship between social class and elitism, especially in the private health sector, because these institutions are looking for additional attributes in the personnel in charge of caring for the patients, who are more valued by an elitist group. As one nurse noted:

> ***You have to be well educated, appropriate with the correct words [because patients want good service], so the private hospital asks you to act with the stereotype profile. If you do not assume it, you have to go. It is an institutional image.***

The conflict for nurses is more related to social class stratification in the public care sector and to elitism in the private sector. This stratification in Chile is more visible in public hospitals, which have rigid hierarchical structures with the director at the top, managers, then

staff, and, at the bottom, the patients and families, who have lower social status. In private hospitals, however, the barriers tend to come from the elite society and the belief in higher social value because of wealth. In terms of the elite class, the nurses agreed that in private hospitals factors such as your name and your address are important. One nurse lamented, ***"Our society is elitist; for example, families are really demanding with nursing aides, less with nurses, and keep silent with physicians."***

All of the nurses complained about the difference in class from that of physicians, which includes salaries and authority/power relations. Nursing is seen as disadvantaged because it is part of the middle class and a female profession.

Machismo

The participants agreed that Chilean society is still chauvinist in terms of *machismo*, the traditional and conservative society that has a strong division of gender roles. In Chilean culture and its conservative society it is assumed that ***"men have to bring home the money."*** This does not reflect reality because there are almost as many female workers as males (43% of the workforce in the Chilean census of 2002). Machismo is on the decline; however, the nurses claimed that it is evident in other ways, that women have multiple roles: ***"Women in Chile must be strong in many ways, do everything; I am mother and father with my children."*** As one manager contended, ***"There are also roles of mother, household manager, or boss of the house and wife; I think many roles at the same time. And we learned in this way culturally."***

Machismo is the social belief that the roles of women and men are associated with different "biological" attributes that are learned naturally, and they are expected to be evident in societies such as those found in Latin America. According to one nurse, ***"Women learned to have more home-related responsibilities and are dedicated—to be a good nurse, a good household manager, and a good mother."*** In a machismo society that equates women with mothers, men do not take care of their children. Often nurses' dilemmas are related to coordinating responsibilities both at work and in the home. One nurse concluded, ***"Women take more responsibilities in the***

home, and our professional development is left in second place." Machismo as a social value may lead women in nursing as a gendered profession to exhibit careful and docile behaviours.

Machismo culture assumes that it is right for women to be followers of their husbands. One nurse remarked, ***"It is a cultural thing that they teach us."*** The nurses believed that women's careers are not seen as a priority, that husbands have the expectation of attaining better positions and careers. Hence, to actualize their professional potential, nurses depend on husbands who are open minded and accept women who work, while also being obliged to fulfill additional jobs as primary keeper of the home and caregiver for their children.

Some nurses also accepted that nursing is a female job, which one head nurse justified: ***"Because women are different from men, women have woman's work, and care is woman's work."*** Another nurse admitted, ***"I prefer to go a male gynecologist rather than a female one."*** Alternately, some nurses see machismo as giving more opportunities to male nurses. Therefore, nurses' identities as working women embrace their multiple roles and the cultural restrictions of gender that affect their lives.

The nurses perceived their relationships with physicians as more complex because most physicians are male. Nurses as women are viewed as dependent on physicians' orders. One manager explained that because ***"he"*** who cures is a physician, cure has more prestige than care. This manager noted that society values nurses less than it does physicians in terms of gender and social recognition: ***"Physicians are more credible; however, we [nurses] spend 24 hours with patients and solve many of the problems."*** In Chilean society, nurses view male physicians as creating a problem of gender competition because, as one nurse noted, ***"physicians do not like nurses to think, and patients believe that they [physicians] are in charge of their health."***

Machismo in the physician-nurse relationship is seen as a barrier to the development of a more professional, prestigious image for nurses; however, there is resistance within nursing. As one nurse articulated, ***"We [nurses] don't have to be there to be in the physician's shadow. They have to shine and look good, and we do the work. It is a gendered servility, and we cannot be***

more than they can." Moreover, in the private hospitals it is a critical point when it is related to role struggle: ***"Physicians are seen as saviours of people, and we are only their helpers. If a nurse is really brilliant, she has to go."*** As a consequence, the relationship between physicians and nurses cannot be equal because of the social constraints for women as nurses.

In conclusion, the participants suggested that machismo affects nurses in various ways. It is easier for men to become professionals because they have more opportunities in education, as well as better remuneration. The nurses agreed that nurses as workers have many roles and responsibilities in hospitals, and they are even more overworked at home. They felt that nurses' work is invisible because they share responsibilities, whereas physicians, who have more authority, have more visible responsibilities. There is also a strong cultural pattern mandating that women marry and raise children as their primary, or even exclusive, role. To be professionally ambitious is to contradict the expected culturally mandated behaviours and roles.

Discrimination and Racism

As middle-class professionals, the nurses realized that female caregivers are viewed as less valuable than males. As one nurse noted, ***"Women's work is not valued; it is convenient because they pay them less, including women managers."*** Women are not recognized in terms of salaries, and the nurses realized that they are not paid well because of gender differences. They agreed that racial discrimination is not an important issue affecting nursing. Little racism is found, but discrimination is experienced. As one manager said, ***"We don't have many ethnic groups. But we discriminate by status and address. In the private hospitals you have to protect a specific group, people with high status."*** Racism issues could be better identified if the indigenous population were studied, but such considerations were not part of this research. Discrimination related to age or gender is evident in some units in the public hospitals, whereas in the private hospitals discrimination may be caused for reasons such as marital condition, name, age, or physical appearance.

The nursing staff, particularly those from the public sector, agreed that racism does not exist, but rather, it is ***"more xenophobia"*** against other groups in terms of job competition, such as with people from neighbouring countries such as Peru and Ecuador in the case of Chile. Xenophobia prevents nurses from these countries from easily finding a job. One nurse affirmed that in the private sector, ***"they tend to accept more the beauty of blonde hair, blue eyes. That's what I have heard."*** In the last decade a migration of nurses from Peru, Ecuador, and Cuba occurred, and they applied for jobs after successfully completing programs at the University of Chile. These immigrant nurses are sent to rural or community areas where positions are more available rather than in the public hospitals.

Image and Physical Appearance

Managers in the public and private hospitals agreed that personal image is related to physical attributes and status. Managers in private hospitals added that physical appearance is important to any professional in Chile: ***"It is important that you look good, physically."*** There is a trend to emphasize not only physical appearance, but also a pleasant, docile attitude: ***"We have to put forward our best smile and our best attitude."*** Nurses in the private hospitals tend to identify more strongly with their public image, which involves, as one nurse observed, ***"personal appearance, pleasant attitude, good preparation, judgment, and obviously submission."*** There is a clear relationship between physical attributes and female behaviour that values being invisible and submissive.

Head nurses in public hospitals identified the impression that beauty is always welcome. Head nurses in private hospitals detailed what is preferred: ***"Good looks, not in body, but as a good-looking nurse: good clothes and good care. But yes, . . . there is physical discrimination as sex symbols with some stereotypes of physical attributes."*** Managers in private hospitals always described the nursing profile as including nurses who are knowledgeable and ***"good looking."*** Nurses in private hospitals affirmed that physical looks are very important, especially in cities such as the capital, where there is a more developed complement of nurses in the market.

According to the nurses, physicians are very "touchy" and controlling with regard to the beauty of nurses because they often suggest that attractive nurses are more competent. One nurse confirmed, ***"They [as men] like to see beauty around them."*** The nurses still believed, however, that they are accepted for their abilities and competencies, but they had some concerns about the future:

> ***Now as professionals nurses are valued for our CV [curriculum vitae], but I am not so sure about the future. Beauty is more accepted in power relationships; it is the highest level of communication with people in the highest position.***

The nursing staff noted that there is a stereotype in the media, such as on television and in comics, of nurses as sex symbols who use syringes with sex-symbol beauty, but they are considered silly; as one nurse commented sarcastically, ***"with a fancy dress and with a syringe in one hand."*** Appearance is very important in Chilean society, as well as the image of nurses presented in the media: ***"On TV women must be blonde, [light] skinned, with long legs, be sexy, but as nurses must always smile."*** The nurses noted that their stereotyped image as sex objects is similar to the image of secretaries. In private hospitals, moreover, physical attributes are synonymous with prestige: ***"It is notorious that the good-looking nurses are promoted most often, and it is true, they get more attention. Here, it is notorious***!"

Therefore, the nurses perceived physical attributes as influential in attaining positions in the hospital's hierarchy and connected with power. The image of nurses in the media is a clear reflection of the message that nurses are perceived as ***"beautiful, delicate nature, docile, as well as giving care as part of the nursing image of that society."*** Powerful symbols from the media result in nursing stereotypes and contribute to the inability of nurses to foster a professional image.

Similarities and Differences

The nurses interviewed agreed on important external issues that affect nurses as individuals and as professionals. They saw social forces as constraining the profession. Chilean

society is consumer oriented and competitive, with a high degree of class struggle and economic elitism, as well as a machismo culture and some forms of discrimination. In the traditional culture, motherhood is highly valued over professional advancement. First, social class stratification is predominant in Chilean society. Second, discrimination by gender is a highly contentious issue for nurses because nursing is a female-oriented profession in a society with an orientation to machismo, which contributes to the higher value of certain roles (e.g., mother, wife) and responsibilities for women. Third, nursing tends to be women's work, and nurses perceived themselves as discriminated against both in the workplace and in public spaces. Finally, physical appearance is valued, and stereotypes of beauty connected with nursing care have increasingly been given attention in the media and propaganda, especially in the private sector.

Nurses in Positions of Leadership in Chile.

Although much of the data were collected from practising nurses and nurse administrators, I also considered collecting the views of nurses working in the Ministry of Health and in professional nursing associations as important. These data are presented next.

The Ministry of Health (MOH) offices are located in the capital's downtown, where the main authorities and workers are concentrated. The MOH has the mission of creating policies and norms for the 29 regional decentralized public health services. Initially, I contacted a nurse who was the main advisor to the minister, but two months later the appointment of a new Minister of Health created changes. To collect the best quality of information, I chose two leaders from the new Ministry of Health team.

The Chilean Nurses Association (CHNC) is a voluntary professional association that has its main offices in the capital; it has a national executive with the main leader as president. Because of the geographic distances in Chile, it also has 11 consultant divisions that are

representative of each geographic location. For this research I interviewed three leaders in two regional locations and in the Centre.

The Chilean Nursing Education Association (CHNEA; formerly the Chilean Nursing Schools Society) has two executives; one is chosen by active members, and the amplified directory is comprised of all directors and/or their designates from the affiliated nursing schools. The CHNEA does not have a physical office structure; however, it is assumed that the president is working at the university level and has the responsibility for conducting the association from that location. For this research I interviewed two leaders of the CHNEA.

A summary of the Chilean nursing associations, their purposes, and the eligibility requirements for membership are shown in Table 24.

Table 24

The Main Chilean Nurses' Associations by Purpose and Eligibility

Name of Association	Purpose	Eligibility
Chilean Nurses Association (CHNC) Colegio de Enfermeras de Chile (CEC)	To head the development of nursing in Chile and supervise the professional service of nurses and qualifying nurses.	Mainly a baccalaureate in nursing or equivalent, and must contribute 2% of the gross salary.
Chilean Nursing Education Association (CHNEA) – Asociacion Chilena de Educacion en Enfermeria ACHIEN)	To influence the education of nurses through leadership.	Older than 21, a baccalaureate in nursing or equivalent, and teaching in a nursing school affiliated with the association.
Chilean Nursing Student Association (NSA) & Federacion de Estudiantes de Enfermeria de Chile (FENEECH)	To provide students with representation and a voice in universities with nursing associations.	All students in a university undergraduate nursing program.

Ministry of Health

In the MOH the distribution of departments and programs is hierarchical in its organizational structure. In the field notes that I took from the organizational chart, I recorded that nurses are involved in some programs and units (child care, immunization, and chronic), and at the time of the visit (in 2001) there was one chair of Senior Programs, but they lack a department. Nurses have high mobility because from the 1990s until 2002 there were five different health ministers, all of whom made changes with regard to personnel in the organization. Nurses in the MOH have been employed depending on the needs of each health minister. In terms of recruitment of nurses into the MOH, those who are recruited vary in qualifications, with selection based on career experience as well as political involvement within the different units in the ministry. Chairs of departments exercise discipline and conduct evaluation; however, the procedures vary depending on the types of contracts and responsibilities that one assumes.

The various departments and units of the MOH had a total of 25 nurses, but one leader noted that ***"nurses have little influence here, almost none, because we do not have structure; therefore we are everywhere in programs, services, units, but not as a unified nursing department."*** (*"Las enfermeras aquí tienen poca influencia, porque no tenemos estructura, entonces estamos en todas partes como en programas, servicios, unidades, pero no como un departamento de enfermería unido."*) In many respects, as will be seen in the following sections, the MOH nurses who were interviewed validated the information provided by hospital nurses.

Advances in the education of nurses. When one leader referred to the education of nurses throughout the last 30 years, she noted that ***"in the past we did not pay fees, [and] we were more socially involved, with a more service attitude. But after the '80s, nursing education was more technical than oriented to the social sciences."*** She added, ***"New graduates must pay their fees and loans and are oriented to job expectations where they can earn higher salaries."*** The leaders saw that the new graduates from private universities preferred private health institutions as places of employment.

Nursing and other programs are addressed by the Ministry of Education. The Ministry of Health is related to the Ministry of Education through its participation in a mixed committee of health and education stakeholders within the public system. Both ministries have as part of their mission solving conflicts between policies of the Organic Constitutional Law (Education Law #18.962, March 1990), which governs the regulation of high or superior education, and the Sanitary Code Law (1977), through which the MOH regulates and protects the population. One leader reported that there is permanent conflict and tension between the laws in the public and private systems because of their incompatibilities. The organic constitutional law

> ***gives a rigid framework and at times is in complete opposition to the Sanitary Code Law and the mission to protect the public. In the case of the private sector, however, they are more involved with the free market, and it is not regulated.***

At the time of the interview there was a conflict with private institutes that had graduated "nursing technicians" without sufficient competencies approved by the MOH.

In the context of the development of nursing programs, the leaders noted that they have experienced some advances, but not enough. For example, the National Committee of Accreditation, CONDA (an organization comprised of university authorities that is autonomous in deciding on its function), develops policies. However, CONDA ***"includes deans of medicine who are dedicated to caring more about the training of physicians than about the education of other health professions."*** Since 2002 the CHNEA has begun to participate in this committee by offering advice regarding the new nursing programs. One leader contended, ***"But I know too that some universities do not accept the recommendation, because they can work alone."*** Nursing programs at the university level are difficult to regulate because universities act autonomously in developing their programs.

In terms of differences between private and public education provided by public and private universities, one leader said, ***"I do not know; my impression is that academics are moving from the public to the private sector. Moreover, new graduates are now giving***

instructions or classes in the private sector." (*"No se, . . . mi impresión es que los académicos se están movilizando desde el sector público al privado. Mas aún, los recién egresados están haciendo clases en el sector privado."*) In addition, this leader was worried about new nursing programs in the private sector because

> ***the faculty members or instructors lack experience, but the point is that new graduates are attracted by the prospect of better salaries, and because private universities are interested in having more professors with practical experience rather than with higher levels or academic degrees.*** (*"Los académicos o instructores no tienen experiencia, pero el punto es que los recién egresados son atraídos por la posibilidad de mejores salarios y a la vez las universidades privadas están interesadas en tener mas profesores con experiencia práctica que aquellos con alto nivel o con grados académico."*)

Advances in the practice of nurses. The leaders lauded the new opportunities to practise professional nursing as many new job positions become available; however, in the current transition of Chilean society, there is a ***"need for a complementary, well-articulated plan"*** for education and the practice of nursing. One leader wished ***"to see more cooperation in [curricula], the preparation of nursing programs, with more sharing of tools and new educational advances; and second, in the workplace, where nurses can apply their knowledge and skills***." It is needed, as this leader noted, to create synchronized educational and professional profiles.

In terms of the organizational structure of the MOH, the leaders noted the lack of an independent nursing structure: ***"There is no Council Nursing Office, and as in all the public health system, there is no nursing department."*** One leader of the MOH recalled, ***"It was an independent organizational structure in hospitals until the 1980s, but because certain medical authorities said that only physicians could be in charge of the hospitals, then the nursing department was eliminated***." Therefore, nurses who work in the MOH are dispersed.

The main challenge for nurses, according to one leader, is to become more professional and to stop concentrating on only the technical aspect of nursing: ***"I have no doubt that nurses***

were educated professionally with sufficient preparation and tools such as in management, research, and teaching. But move forward!" One leader discussed a constraint for nurses:

> ***We don't have clarity about our role. We believe in the culture that we are professionals and we practise the scientific knowledge, but in reality we still have a medical culture, because everything is related to curing and without the vision of health. . . . This ministry should be named Ministry of Illness. And you must also remember that we are living in a market economy society.*** (*"Nosotras /os no tenemos claridad de nuestro rol. Creemos el la cultura y percepción que somos profesionales y practicamos el método científico, pero en la realidad tenemos la cultura médica porque todo está relacionado con el curar, y sin la visión de la salud... Este ministerio debería ser llamado el Ministerio de la Enfermedad. Y recuerda además, que estamos viviendo en una sociedad de mercado."*)

Barriers and expectations. One leader concluded that important barriers that limit professional nursing include:

> ***First, nurses do not have a structure in hospitals such as nursing units or departments. There is little development of nursing policies in education and practice, a lack of information on the Sanitary Code with legal support for all nurses, and a weak union in the affiliation with professional associations.***

Second, the leaders recognized that there is still a lack of nursing resources in the public hospitals. One participant argued, ***"There is no substantial improvement because there is no policy providing specific direction, and the Ministry of Health lacks adequate financial resources, and so new positions are not created."*** Third, both leaders agreed that nurses must have a greater role in the management of care and become more involved in decision making. More graduate programs are needed. Good training and up-to-date knowledge are key elements in promoting a better future for nursing. Nursing leaders from the MOH agreed that nurses ***"are still facing barriers in policies and legal restrictions—consequences of a long period of democracy rebuilding—which have not yet been recovered."*** One leader advised that advances in practice and education settings must be complementary, but three important factors must be addressed: ***"First, the creation of the nursing structure as a department in all hospitals, including the Ministry of Health; second, more recognition through salaries and professional development; and third, changes in nurses themselves as well as in society."*** Both leaders agreed that the main

issue for nurses in the long term is the expectation of achieving more autonomy, better working conditions, and recognition.

Chilean Nursing Association (CHNC)

The CHNC, which was created by Law #11.161 in 1953 as a public professional association, is a hierarchical organization whose structure has been developed according to historical and political shifts in the country. Radical changes occurred during the 1980s as a result of Law #2757, which granted the association the status of a private professional association. The CHNC is the main voice of professional nurses and is the representative of Chilean nurses at national and international events.

CHNC and its priorities. The main leader identified the activities and priorities that the nursing leaders of the CHNC considered most important:

> ***First, to increase participation in decision making about health policies in Chile and about the new health reform led by the government, which does not satisfy us. Second, to promote the health reforms with reparation of injustices and inequalities, with participation of workers, leaders, and the whole community. Third, to be included in the Sanitary Code, which has given nursing a legal framework since 1997 and therefore allows nurses to be more visible with respect to nursing services. Fourth, to address the lack of nursing structure in health care organizations, which still remains because of the lack of sufficient political support to change it.***

The working conditions of nurses in both the public and private health sectors, according to one leader, ***"consist of four groups of nurses' working conditions."*** She explained that in the public health sector there are two groups of nurses who demand higher salaries: ***"The government public health sector and the primary health care sector both have different agendas and ways to negotiate collectively."*** In the private health sector nurses are governed under Labour Law #220, which is related to collective negotiation; however, the leader added, "***Private hospitals do not like unions, and they break or destroy them by firing the worker/leaders."*** Another group that "***we would like to approach is the independent new entrepreneur nurses"*** who are owners of clinics and private nursing services (e.g., senior or home care).

Issues in the CHNC. Besides national health reform, the CHNC addresses three important issues. First, the legal framework in the Sanitary Code is important because since 1997, one leader noted, ***"Nurses have had to protect or defend their rights in court."*** Second, mandatory registration is an important goal. ***"It is considered a dream"***; however, one project to accomplish this remains with the Chamber of Deputies and has little chance of being approved, although ***"in my opinion and with my political experience, each project takes five years to be approved and maybe more."*** Third, the working conditions of nurses, as part of the main agenda, are a consequence of what occurred in nursing in the health market. One leader ***"would like our role to be seen as more competent and this recognition to be seen in our responsibilities with the corresponding authority. After that, then we can relate salary with the description of our roles and functions."*** (*"Nos gustaria que nuestros roles fueran vistos como mas competentes y este reconocimiento visto en las responsabilidades con la autoridad correspondiente. Cuando esto suceda, entonces podemos relacionar el salario con la descripcion de nuestros roles y funciones."*) Nurses' salaries are not good, she added and are sometimes lower in the private sector than in the public sector. One of the leaders concluded, ***"Nurses need more recognition in their functions, roles, and responsibilities."***

Democratization of the CHNC. Regional leaders are associated with the national CHNC, which has relatively low participation. According to one regional leader, ***"We go to meetings when invited, but our opinion is not always listened to as a contribution."*** Within the organization, in the eyes of regional presidents, ***"their voices and participation are part of the process of democratization in the CHNC."*** Democratization of the CHNC is vital, as both regional leaders of the CHNC noted: ***"[We] realize that this organization has been functioning similar to a boss with subordinates, and not with colleagues."***

Consequently, the national and regional leaders of the CHNC have different agendas and responsibilities. With respect to a national central agenda, national leaders promote health care reform and its policies through political action. The CHNC is faced with, as the national leader

remarked, ***"more or less political power in the different associations where they must participate and face authorities as the main group of decision makers in the country."*** Additionally, regional presidents are not only responsible for understanding the national context, but also for communicating the news to nurse affiliates. They are also charged with making nurses more visible at the regional level.

CHNC and membership. In general, the leaders of the CHNC were conscious of the lack of motivation and interest in affiliation with the association. One leader said, ***"We are concerned; we know that some individuals are not informed about the benefits of being affiliated. . . . The new graduates and older nurses have more of an interest; both participate the most."*** These leaders believed that one way to increase affiliation is to conduct a permanent campaign to disperse broad information to make nurses aware of how important it is to have a strong association as their natural home where, according to one leader, ***"they can find support, assistance, be listened to, and be advised on labour conditions, and ask questions as a big family."*** The leaders discussed a new Chilean society ***"in which the principles of solidarity have been replaced by a new vision of individualism that does not consider solidarity."*** Nurses who do not participate lack motivation: ***"I think nurses who are not affiliated are nurses who are quite invisible; it seems as if they do not exist."*** The CHNC has run many campaigns to affiliate nurses, and the results have been generally satisfactory. However, when I asked how many affiliates exist now, one leader responded, ***"I won't tell you the official number of affiliates."*** The CHNC helps affiliated members in a variety of ways: ***"We have an assistant program in our association; we help nurses with troubles such as health and psychological problems, and now we are including legal advice for them."***

The leaders wanted mandatory registration and planned to pursue this goal. ***"Chile is a free-market society,"*** one leader explained, ***". . . and there is no regulation in education and preparation as professionalism is out of CHNC control."*** The regional leaders reported that in their regions an average of 60% to 70% of all nurses are affiliated. Because of legal prosecution

against some nurses last year, the regional offices have seen membership increase as nurses become affiliated for protection. One leader added, ***"Although some nurses are not registered, they still receive legal support."*** The regional leaders noted that they employ strategies to encourage affiliation; for example, ***"Executives are hired to recruit nurses, and their payments can be made directly by credit card."*** The strategies to increase affiliation are focused on two groups: ***"the private sector and primary health care nurses."***

CHNC and assertiveness. The leaders would like to have at the national level a structure of nursing organizations in the public and private health sectors and more recognition of nurses by paying them a fair salary. One regional president believed that in five years nurses will have to create a new nursing culture as a group or collective working for the same interests: ***"We have a lost or spoiled generation. This generation [of nurses] are experts technically, but nothing more."*** Other leaders hoped to increase affiliation from 70% to 100% and have more active participation. More ambitious plans for the long term included positioning nurses to achieve better status as professionals. To pursue this plan, one leader identified three requirements: ***"First, nurses need to be more involved politically; second, they need to have more interest in the organization; and third, [they need to] have stronger leadership and more commitment to professional issues by all unions."*** Both regional leaders wanted to see within 10 years separate national and regional consultant centres, with more participation of nurses, which is essential as regional leaders travel from one part of the region to another, covering vast areas: ***"If I am going to another city, I need one day."***

CHNC and opportunities and connections. The CHNC is involved in many meetings with governmental authorities, including those from the Ministries of Health, Education, Work, and Women, and other associations. The CHNC struggles with the MOH because the relationship is constantly conflictual and there are frequent changes of ministers. There is neither the time nor sufficient membership to cover issues well. One leader commented, ***"We are like helicopters flying everywhere; we see the whole with a broad vision of its parts."*** (*"Nosotros somos como*

helicópteros que volamos por todas partes, que vemos el todo con una amplia visión de las partes.")

The leaders perceived a lack of interaction and connection among nurses in education and those in practice. The main barrier created by the nursing education sector is that ***"we have few chairs of nursing schools who are accessible, because they keep themselves distant from us."*** The CHNC is sceptical and concerned about new undergraduate nursing programs

> ***because there is a limited structure, with few faculty members, and even they are not well qualified. The real problem that they have is to recruit students, which is beyond the control of the CHNC; as a result, one does not know when the market will be saturated and what will happen with many new graduates.***

The CHNC has attempted to become more connected with nursing schools through its main leaders and the chairs of schools, while also meeting with educational authorities to increase regulation of the nursing programs. The problems remain, however, as the new programs emerge with a lack of regulations. One leader explained, ***"If it is a new private university, they are autonomous; we cannot tell them anything."*** In the public universities there are always advances and retreats with chairs of some of the nursing schools, but the CHNC has been working with students of each NSA conglomerated under the FENEECH (the Federation of Chilean Nursing Students).

The CHNC has a tenuous relationship with the CHNEA, which, upon further examination, is actually quite separate. As one leader described it, it is ***"basically formal."*** Depending on the geographic location, however, the CHNC can have good communications and fluent relations with the universities' nursing leaders. In other regions the leaders have stronger connections with professional associations and unions; for example, the National Federation of Health Workers (FENATS) and the Federation of Professional Health Workers (APRUFEN). At the international level it has a relationship with the International Council of Nursing, on which one member has a seat, ***"which means a strong representation and voice at an international level."*** The CHNC currently has the vice presidency of AFEPPEN, a federation of nursing

associations at the Latin American level. Thus CHNC has the international connections required to participate in discussions of nursing issues at various international levels.

The Chilean Nursing Education Association (CHNEA)

The CHNEA was founded when all nursing programs were public in the old nursing schools. With the educational reform of the 1980s and with new nursing schools and programs, the organization implemented a legal structure in 1999 that has thus been able to bring more support to the organization.

Main priorities of the CHNEA. ***"Our mission and purpose,"*** the main leader noted, ***"are to control nursing programs, and our main objective is that curricula be similar."*** Both leaders agreed that the priority of the CHNEA is control over education to protect the quality of bachelor's degrees by offering the same program in all nursing schools. Another goal ***"is to clarify that nursing programs are offered exclusively at the university level with a bachelor degree."*** (*"La importante tarea de la CHNEA es clarificar que los programas de enfermería son ofrecidos exclusivamente en las universidades con grado de bachillerato."*) The CHNEA was concerned that with the Constitutional Organic Law of Education (LOCE), which is the ruling body that regulates all university programs, ***"There is no clear definition of nursing requirements for undergraduate degree programs."*** Thus the law allows nursing programs to be provided in any institution and not exclusively at a university level.

The CHNEA also advises on ***"ways to improve educational preparation and to ensure adequate numbers of faculty members"*** and on developing curricula and nursing programs. One leader explained:

> ***Procedures for giving free consultation are, nursing schools send their programs, and then they are evaluated by CHNEA, which makes comments or judgments about whether the program is similar to what the CHNEA recommends. [However,] we need to have a minimum level of competencies in nursing programs and also must address epidemiological and demographic context.***

The problem with these recommendations is the independence of each nursing program. As one leader argued, ***"We have little control over nursing programs, which should graduate the best quality of professionals."*** She noted that offering advice to nursing schools that are implementing new programs ***"is not sufficient because acceptance of advice is totally voluntary."*** Legally, the CHNEA does not have control over curricula in any university in Chile, but one leader contended that ***"the reason that some nursing schools follow advice is because of the prestige of CHNEA."*** Because of this prestige, the CHNEA has had some success; for example, the achievement in 1995 of setting standards for the bachelor of nursing programs in all universities.

Since 1993 the CHNEA has had a document of accreditation, one leader informed me, that ***"was restructured according to the rules and regulations of the Ministry of Education, but they are not effective because of the lack of legal authority."*** Therefore, the CHNEA is now recognized as the nursing organization by the Education Ministry and is working through a National Commission of Accreditation (CONDA) to create an instrument to evaluate all nursing programs for accreditation. Nursing graduate programs are completely autonomous, and each institution decides whether or not it will offer a graduate program. However, one leader noted, ***"I think that CHNEA is more interested in undergraduate than graduate nursing programs."***

The CHNEA and membership. After a reform of the statute in 2001, a leader of the CHNEA affirmed, ***"We have [had] to make procedures to affiliate more new faculty members, instructors, and also new nursing schools."*** Historically, the CHNEA was initially more of a female academic association with a vision of high status at the university level. One leader recognized that ***"perhaps we were wrong to be an elitist group. We worked with directors of schools, but little with the lower levels."*** The number of faculty members affiliated with the CHNEA is generally low, but in recent years affiliation has increased, and it has become more attractive and essential for new faculty members to become affiliates.

The CHNEA and connections. The relationship between the CHNEA and the CHNC, explained both leaders, ***"is formal,"*** one that lacks a strong commitment to work together. The

CHNEA accepts that the CHNC is concerned with the educational part of the profession, but both are worried about questions related to education and training. One leader acknowledged, ***"In general, we have to share. The CHNC and CHNEA pursue the same purpose, which is the monopoly of practice and having a legal framework under which nurses practice. But we do not always work together."*** These associations need to compromise to work together to improve nursing education. In general, there is a good formal relationship, but, as one leader observed, ***"The CHNC has been working hard, but not always as a conglomerate of all nurses of the country because there are many nurses who do not feel represented by CHNC."***

The relationship between the CHNEA and the MOH is more ***"informal."*** Sometimes the MOH invites them to participate as guests on commissions or requests profiles. Then the CHNEA participates with its opinions. Internationally, the CHNEA has connections with the Latin American Association of Nursing Schools and Faculties (ALADEFE), whose role is similar to that of CHNEA. At the Latin American level it is a network of nursing schools linked with PAHO to promote education and research. One Chilean nurse leader is in the executive board of ALADEFE, and she noted that ***"we would like more preparation through long distance courses, exchange programs, and support of doctoral programs in nursing in Latin America."*** Approximately 200 organizations are affiliated with ALADEFE; the importance of affiliation is to extend international contacts as the globalization of network groups of nurses continues. At a regional level, one leader noted, ***"Our nursing undergraduate programs are viewed with great prestige in the region, and at the graduate level there are excellent programs in Brazil."***

The CHNEA and expectations. Three important expectations of the CHNEA are to ***"accredit all nursing schools, create new nursing graduate programs under our vigilance, and strengthen research in the field of nursing."*** With more new nursing programs and with changes in the educational system, one leader of CHNEA asserted, ***"We want a better product, with more strength and support."*** Few nursing schools are accredited, however, and the CHNEA hopes to accredit all nursing programs.

One of the CHNEA's strategies was to hold a meeting with universities and colleagues to participate in planning the future of graduate programs. As a result, one leader reported, ***"With 60 participants and under critical analysis, they concluded that master's and doctoral levels are needed, including some specialization in geriatrics, dialysis, palliative care, and home care."*** The CHNEA recommended at that congress ***"to advance more in research through master's and doctoral programs and create policies to accomplish this."*** There is new funding support for research such as the government fund FONDECYT, and now special funding for the health field for which nurses can apply. As a research strategy, one leader explained:

> ***We have formed a creative group of researchers, and we are trying to do collaborative research projects across universities. We have to correct the mistake of doing something for only one university, or the mistake of lack of background knowledge. We have a team of researchers working on some guidelines to help other universities that are not yet well developed.***

Research in Chile was seen by one leader as ***"taking off,"*** but another leader felt that ***"nurses have to publish more and find more funding, especially now that there is new funding from a national program that nurses should use."*** In 2002 I had the opportunity to assist one collaborative research network between the CHNEA and New York University, where there is a partnership to create the International Nursing Research Centre (see the website at http://www.achieen.cl/ciienf.htm).

Leaders and Their Vision of Social Barriers

Social barriers and problems of nurses themselves were also identified by the leaders. For example, one leader of the MOH mentioned a study in the early 1990s on the problems of the public health sector related to the patriarchal culture of poverty and the low satisfaction of patients. In a gender analysis (approximately 75% of total health workers are women) it was found that

> ***there was an interesting connection where formerly women were socialized in a machismo culture, that emphasized the characteristics of beauty, obedience, kindness, and a "good girl" attitude. As a consequence, women were rewarded with the love of***

> ***their life and the mother's role. Therefore, women compete with other women and see each other as rivals or enemies. [There is] a social and gender struggle in the relation of women as wives and in the hospitals as workers, with the different levels of physicians, nurses, and nursing aides, all with different cultural and educational backgrounds, resulting in conflict and competition.***

With these results, a recommendation was made to emphasize the need for more empowerment in terms of gender for health workers. Leaders in the MOH disagreed that discrimination in the public health sector exists, but in private hospitals, ***"we knew about some cases, such as dark skin, name, or something related."***

The leaders of the CHNC were aware of social class struggles and gender divisions in society. Moreover, they noted that the traditional status and roles of women discourage their public roles in society because they are excluded, for example, from the roles of politicians, activists, or leaders. They adamantly agreed that chauvinism exists in our society in Latin America: ***"Women believe and assume that motherhood and having children are the priority in their lives."*** The roles assumed by female nurses are expanded somewhat; as one leader noted, ***"not only to be a mother, but also wife and excellent nurse."*** In terms of the political commitment of nurses, the national leader noted that few nurses are involved because, culturally, ***"compared to women who are married, husbands have much more time to participate in politics and political activity."*** One leader discussed external factors in the social systems that put nurses down, but ***"nurses do not really participate in anything as social beings."*** Another leader complained that women have been discriminated against for a long time and that nurses are placed in the middle as women and nurses (similar to housekeepers in the hospitals), and this condition is replicated in their professional positions: ***"I see that we are doers more than thinkers. . . . There is a defect from the beginning in our old nursing programs. The prototype of nurses is that we do certain things, but nothing more— . . . so lethargic!"***

Therefore, what the CHNC leaders shared was a desire for nurses to seize opportunities and become more visible in meetings in the political arena. Nurses need to reculture nursing

because they are living in a freer economic society. An effective strategy of the CHNC leaders as political activists is to persist in their agenda for enough time and the right attitude to be demanding, negotiate actively, and use collective strength as much as possible. The CHNEA leaders argued that at a societal level nurses need more social recognition, better status, and more visibility.

The leaders of the CHNEA identified one barrier as the elitism or classism in the historical evolution of nursing in Chile. One leader suggested that it means that nurses are not well prepared culturally to fight for more prestige for the profession:

> ***We do not have time to improve or refine the social skills of our nursing students. We would like to give them more. It is difficult when they have to provide care to a manager or a janitor from different social classes.***

She seemed to perceive a status problem that constrains nurses' prestige and recognition. Moreover, one leader added:

> ***The students are smart but have to struggle against discrimination. For example, they have limitations in speaking well. There is no doubt that there is better selection in the private nursing schools because they have to speak well, behave appropriately, and look good.***

The second barrier is that nurses as faculty members have gender obstacles, one of which is that ***"salaries are low or nurses are preoccupied with their children. But I don't see male nurses in education too much."***

Reflections on the Leaders' Visions

The leaders who were interviewed offered complementary visions of what is occurring in nurses' education and practice. These leaders were very conscious of social barriers that derive from social forces such as machismo, social class, elitism, and conditions of women's work. With their common vision, they are striving to achieve more of a monopoly over professional issues. Leaders of the MOH are involved in the policy arena; however, they lack the power of a professional group to have discussions and make proposals because they have neither a nursing

department nor a strong influence with the CHNC. Nurses in both professional organizations work together reactively, not proactively, as part of a larger purpose. Nurses at the national level of the CHNC are involved mainly with active participation in national health reform, and regional leaders are more involved with working locally and with the legal situations of nurses. The Chilean Nursing Association and nursing staff in practice are not well connected, and the lack of affiliation and participation is clearly limiting the strength of the voice of the association. Two groups of nurses have the lowest degree of affiliation, those practicing in the private care health sector and the municipal primary health care sector.

The CHNEA is the organization of nurses involved in nursing educational programs; however, they have little legal power and affiliation. Accreditation of nursing programs is a major goal of the CHNEA. Policy changes and more legal support are also seen as essential in the revolution of nursing education and practice. Social barriers to the development of nursing as a profession were identified, such as the low status of women and the position of nurses in health care hierarchies.

Reflections on the Position and Issues of Nursing in Chile

In Chile I interviewed nurses from three private and three public hospitals in three geographic locations about the nursing profession, and I collected supplementary information from nursing leaders. There are substantial differences between public and private hospitals, but working conditions, with the exception of the availability of resources, are similar, and they are more related to institutional context. All of the hospitals lack nursing departments, and there appears to be a lack of delineation of roles.

Although the respondents agreed that nursing is a profession defined by knowledge, university-level education, and values, nurses are struggling with the development of a unified professional identity. They perceive themselves as lacking recognition from society and co-workers, especially physicians. They work within rigid bureaucratic, hierarchical structures in

public hospitals and with families and patients in more flexible and management-oriented private hospitals. Images of nurses are influenced by important social forces and stereotypes. Leaders noted that nurses work separately rather than as a cohesive single group because of different interests, priorities, and levels of connection. They are all, however, pursuing strategies to develop nursing as a profession with a more independent role for nurses in the practice field, a greater voice in issues that affect them, and more political involvement of nurses.

CHAPTER 8:

WHAT DOES IT MEAN TO BE A PROFESSIONAL FOR CHILEAN NURSES?

Chilean society is characterized by a still-developing democracy with a powerful neoliberal economy in a new configuration of Chilean occupations in the market. Chilean nurses are part of the professional population who possess a university degree. Legislative changes in the 1980s led to loss of licensure and mandatory membership in professional associations. Chilean nurses, organized through nursing associations in conjunction with other professional associations, are struggling to find more space to deal with unresolved and newly emerging issues. In a society in which education and health are mixed in terms of private and public sectors, professional associations have had little positive impact in their negotiations with governmental sectors with regard to regaining control over professional issues of concern to their members.

Between 1960 and 1990, nursing programs in Chile produced a small number of graduates, which resulted in increased stress on the mostly public health care system. The political-economical crisis of the 1980s led to migration of nurses from the university educational sector, closure of nursing schools, loss of departments of nursing in hospitals, and dismissal of nurses in key nursing positions. Since the early 1990s, with new, more mixed public/private health and education systems, there has been an increased demand for nurses, and new positions are now available. In response, private university programs have opened based on market demands, which has led to concerns about standards. Hence, on one hand is the public educational sector with financial restrictions but with emphasis on developing more graduate programs and research, and on the other hand is an emergent private educational sector that tries to enhance its market opportunities by creating new undergraduate nursing programs.

In this chapter the professional status of nursing in Chile is analyzed using the criteria established by Turner and Hodge (1970) and using data provided by Chilean nurses in practice, in education, and in leadership roles, as well as by nursing students. These dimensions include the degree of substantive theory and techniques, the degree of monopoly, the degree of external recognition, and the degree of organization. Interpretation of the findings will be connected to the literature review of nursing as a profession to assess the extent to which Chilean nursing meets the criteria of a profession. Social and feminist theories are used as lenses to enhance the theoretical understanding of forces that affect the professionalization of nursing in Chile.

Degree of Substantive Theory and Techniques

Chilean nurses who work in practice and education and leaders in different organizations who were participants in this study agreed that nursing is a profession because of its theoretical and scientific knowledge. These nurses saw the profession as based on a set of characteristics in which knowledge means 'scientific or theoretical support.' Generally, students felt that substantial theoretical knowledge is introduced at the university level. The dimension of what type of knowledge is desirable, however, was not well defined by these nurses. For example, some nurses referred to applied knowledge rather than scientific knowledge or humanistic knowledge or both. Moreover, a group of nurses perceived that the knowledge must be applicable to practice. Nevertheless, a small number of nurses saw the need to include more specific and unique types of knowledge in the nursing curricula, including a set of theories or theoretical frameworks that fall under a more consistent focus on nursing knowledge.

Consensual agreement of which knowledge and theoretical frameworks have to be included in nursing programs and curricula is also limited by the degree of influence that nursing associations can exert over all university schools of nursing. They do not have control over those nursing schools with new programs because they lack any legal control over curriculum delivery in any universities in Chile. The mixed public/private health and education sectors are regulated

by two ministries, Health and Education. Conflicts are produced when regulations of both ministries must be considered and when two sets of laws can be interpreted differently. Nurses have to deal with the Organic Constitutional Law, which governs the regulation of the university educational system, and with the Sanitary Code Law, which is used by the MOH to regulate and protect the health of the population. In general, the leaders noted that there are fewer conflicts in articulating the rules and procedures in the public education and public health sectors. It is more difficult, however, when it is related to the private sector. For example, the leaders remarked that it is difficult for nurses to control nursing programs in the private universities because these universities and their programs are autonomous.

Since the 1990s the development of nursing as a profession has been well supported in five-year public nursing programs, which prepare nurses with a baccalaureate degree. New concerns have risen, however, over the lack of evaluation or accreditation of nursing programs. The leaders affirmed that the emergent nursing programs respond more to the needs of the university market interest than to the professional collective interest because of the lack of connection of new schools and their nursing chairs with nursing leaders and associations. The Chilean Nursing Association and Chilean Nursing Education Association view these new programs with distrust, and the nursing leaders of the MOH were worried about the qualifications and teaching experience of instructors. In 2003 there were 32 nursing undergraduate programs in 25 nursing schools at the university level. There were 14 traditional public universities offering 15 nursing programs, and 11 private universities offering 18 new nursing programs, with a total recruitment of approximately 2,000 first year students. In 2004, 13 nursing programs opened in the private sector, meaning that a total of 49 nursing programs now exist (V. Behn, personal communication, March 27, 2004). Some nursing schools that offer undergraduate nursing education in more than one geographical location consider that each location has its own program. This explains why the number of programs is greater than the number of schools.

Similarly some schools that offer bilingual programs or programs on an afternoon timetable often consider these variations to also be different programs.

Concerns about the quality of the programs are increasing. This issue is a highly contentious matter for both the Chilean Nursing Association and the Chilean Nursing Education Association, which have standards and accreditation approved by CONDA, the governmental regulator of accreditation at the university level (Corral, 2002a). Nursing programs have different paces of development and various conflicts, which has resulted in a variety of curricula that do not guarantee the inclusion of common nursing knowledge. There is a great deal of variation in nursing education because of the increasing number of new private undergraduate programs with their diverse frameworks and curricula, and the varied qualifications of faculty members. Faculty members of nursing programs in public and private universities did not mention the priority of developing commonalities among curricula; rather, they are pursuing an increase in the number of graduate programs as part of the response to the professional vision to develop strategies to increase professional development. Some faculty members agreed that accreditation and self-evaluation of nursing schools and programs are starting points to learn about the variety of curricula being offered and about what is needed in all undergraduate programs. In fact, most of the schools with nursing programs in the public educational sector are members of CHNEA, and they have tried to have uniform criteria for the development and evaluation of nursing programs, with common basic learning goals. As a result, CHNEA began the accreditation process for one nursing program in the public educational sector in 2003. In addition, with the expansion of nursing programs and seats, the lack of qualifications of new faculty members has raised the issue of whether or not nursing undergraduate programs meet appropriate minimum standards and whether instructors are adequately qualified and competent. When I reviewed the qualifications of nursing instructors in this study, I found that the public sector has better qualified instructors, perhaps because they have been in the educational sector longer. More faculty in the public educational sector reported having masters' and doctoral degrees or specialization in a particular

nursing field. Compared to the public educational sector, the private sector is new and has few highly qualified instructors.

In Chile, between 1980 and 1990, nurses had limited financial and human resources to develop more graduate programs. Thus, nursing graduate programs have been substituted with "certificate programs," which include theoretical-practice seminar/lecture programs, offered mainly in public universities. Certificates are granted after graduate nurses complete a group of courses with a minimum of 20 hours to a maximum of 100 hours. These programs do not lead to degrees or specialization diplomas. Most of the nurses in practice use the certificates as a way of advancing or staying up to date. In 2003 there were three master's degree programs, one doctoral program, and 15 specialization diplomas available in nursing in Chile. From 1990 to 2000 more than 200 nurses graduated from these programs (Jofre, 2003).

Historically, funding for research in nursing has been inadequate, which has limited the development of research and, in turn, nursing knowledge. Since the 1990s, however, there has been a substantial increase in the production of nursing research; the emergence of two new nursing journals is an indicator of this new productivity (i.e., *Horizonte* and *Ciencia y Enfermería*). The leaders noted that new national funding for nursing research has encouraged faculty members and researchers, especially from public universities, to apply for this government funding to conduct research activities. With still little development of the discipline of nursing, the few nursing graduate programs coexist with low preparation of faculty members. In this study the leaders of CHNEA have positive expectations, and the new doctoral program at the University of Concepción is expected to increase preparation in nursing research. The emerging collaborative network of CHNEA with international organizations is seen as another development that could lead to the preparation of more researchers. Nevertheless, interest in research remains limited, and the development of nursing research is slow. In addition, more research emphasis must be placed on increasing nursing knowledge on the development of the discipline in Chile.

Critical Analysis

Understanding the criterion for a profession called the *degree of substantive theory and techniques* for assessing the development of nursing in Chile needs to be contextualized in terms of the long-term impact of health and educational reforms. From a social perspective, historically, Latin America has been influenced by political and economic transformations in the region. Under the Structural Adjustment Plans implemented in the early 1980s as an instrument of the economic neoliberal reform, the liberalization of responsibilities of the state as a benefactor changed toward a vision of the state as a support to private enterprise (Gonzales, 1999; Harris, 2000; Navarro, 1998). More precisely, the education and health sectors are to be left in the hands of competitive market forces with the introduction of cost-efficiency and consumer styles (Barrientos & Lloyd-Sherlock, 2000; Scarpaci, 1988). Therefore, a restructured health sector allowed opportunities to incorporate more privatization and business into health services and ensured that "since the mid-1990s, U.S. managed-care organizations and investment funds have rapidly entered the Latin American market" (Stocker, 1999, p. 1131). In addition, the new mixed educational sector has given rise to opportunities to open new programs in the private sector (Atria, 2000).

Critical social theory involves the critique of the values and ideologies of social institutions and their resulting distortions of reality under the main oppressive forces. In a globalized world, which is characterized by a new era where global 'capital' is the main force, radical changes have created forms of domination (Chomsky, 1999; Mattei, 2003; Navarro, 1998). Education in Latin America increased society's expectations. It was meant to accelerate the progress and standard of living in the region. After a conflicting and turbulent period in most of the countries, however, the reforms have delayed progress. The resulting mixed public/private sectors in education are a consequence of neoliberal strategies that allowed, in the case of nursing education, an expansion into the private education sector. As Gentilli (2000) reported, "Private institutions are attracting growing numbers of students and are beginning to dominate national

university systems. In Brazil, Chile, and Colombia, over half of the student population is enrolled in private universities"(p. 14). Nursing education in Latin America is heterogeneous, and this will continue. Legislative changes in alliance with educational market opportunities have limited the professional associations' control over education. The growth in the number of nursing programs and the variety in curricula, however, are new tendencies that some scholars perceive as positive in nursing. As Gaines (2001) noted, "Research and inquiry in different [nursing] curriculum models is now the norm" (p. 142). This diversity in nursing programs has the potential to both strengthen and weaken the nursing profession.

Historically, professional nursing in Chile has faced external threats throughout its development. For example, the closure of nursing schools in the early 1980s led to years of chronic nursing shortages. With the second period of structural changes in the mid-1980s, nursing programs almost moved to the technical sector and out of universities, but lobbying by CHNC prevented this from happening. The 1990s heralded a complete liberation in the market at the university level, which led to the proliferation of new nursing programs in private universities. The progress of nursing programs in the private sector has been so fast that in three years the universities have doubled the seats in nursing programs, potentially saturating nursing positions within the next few years.

In Chile's rigid paternalistic society, nursing education has been traditionally taught within the structure of medical schools. This has limited self-governance and control over educational planning, a problem once experienced in the USA (Torres, 1981). Such organizational structures in universities reinforce medical paternalism and reproduce the same patterns with hierarchically imposed roles in hospitals, where nursing knowledge is seen as secondary in importance and thus undervalued. In Chile as well as in other places, the education of nurses has been influenced by the 'invisibility of care' because nursing roles appear to extend naturally gendered family roles. The nurse participants in this research admitted that nurses have been aware that their nursing education has promoted submissiveness. Developing substantive

theory recognized as unique nursing knowledge is complex when the relevance of care as a legitimate area of research is undermined by the existing hierarchical knowledge structures. Under the umbrella of patriarchy with its machismo beliefs, as in Latin American countries, women's knowledge, such as that in nursing, is undervalued. Theorists such as Leininger (2002) and Watson (1995a) identified the core of nursing knowledge as caring. In general, it is not only the care that is dismissed, but also the nurses who are perceived as submissive, docile, and incapable of intellectual thought. Caring is seen as natural for women, and therefore nursing is also natural. From a Western perspective, as Reverby (1987) noted, "Because society believes we are in duties of caring we are forced to choose, between altruism (the basis of care) and autonomy (the basis of individual rights)" (p. 5). Most nurses have accepted or chosen the former. In France, for example, Colliere (1986) believed that, historically, nurses' training has been built from the ideology of a moral perspective such as devotion, dedication, assistance, mission, vocation, and what should be right and wrong conduct. A devotion to patients that includes receiving orders from physicians results in an implicit subordination to physicians' thoughts and knowledge. The technical perspective or being helpful to the patient relies on no specific important knowledge. This leads to a situation where "there was nothing to give credit for in nurses' work, no rational basis by which one could assess the efficiency of their tasks except those which revealed technical skills" (p. 102). Nursing in Chile seems to parallel the description of nursing in France, although Chile has embraced university education for n[illegible] contrast to France's greater reliance on diploma-level education.

Caring as a source of knowledge and as a theoretical component of nursing education may be undervalued by Chilean nurses themselves, especially in the public health care system where the caring roles ha[illegible]e been delegated to nurse aides. Nurses have become managers of care and do some work that is usually seen as within the domain of medicine. With the variety of nursing roles, there is probably [illegible]ndency to move toward technological or managerial dimensions rather than to favour the central dimension of nurses as 'caregivers.' Nurses can

assume the stratification of activities and roles in relation to caring and cure, a dualism in which nurses may express more interest in the knowledge exemplified in the medical model than in the knowledge or use of knowledge unique to nursing. There are thus nurses who are well prepared in the medical realm who dismiss the value of caring as an appropriate route to knowledge. This study involved nurses who have been doing medical tasks as part of their extended role, but as Lovell (1981) concluded, "With nurses fully occupied in the performance of minor medical activities, the nursing threat to the medical enterprise is dismissed" (p. 38). Nurses as medical helpers may not support caring as central to the profession of nursing and may not see the goals of nursing research as separate from the goals of medical research.

Degree of Monopoly

The degree of monopoly refers to autonomy over practice and who joins the profession and is related to the recognition that professions possess specialized knowledge and expertise in some field. The degree of monopoly is identified by the extent to which occupations exert control over their professional activities, with credentialing and standards in education and control over licensure of their practitioners perceived as key indicators. As in Canada, "Mandatory licensure has been achieved by emphasizing the need to assure the public that licensed nurses have met an appropriate standard of practice, as determined by the profession" (Ross Kerr, 2003, p. 420). Therefore the degree of monopoly assures minimum standards within a profession. As Larson (1977) believed, monopoly "will allow them to standardize and restrict access to their knowledge, to control their market, and supervise the production of producers" (p. 71). It may also be perceived as a mechanism of control to assure a space in the market for licensed practitioners. In Chile, until 1981 regulations and credentialing through the registration of the members were in the hands of the professional associations. Since then, professional associations have lacked control over these regulations. The CHNC has kept struggling to regain credentialing through licensure and control over members.

Therefore, the connection between education and practice is understood as agreement over the scope of professional activities congruent with educational goals and practice competencies to ensure a good fit between educational programs and nursing service needs. The main nursing association, CHNC, and the nursing education association, CHNEA, have created a coalition to advise the chairs of new undergraduate nursing programs and faculty members of existing nursing programs. As a result, CHNEA has been recognized as the nursing organization responsible for advising the Education Ministry as part of the National Committee of Accreditation (CONDA), an organization with an autonomous committee that involves faculty members who are primarily from the public university sector. CHNEA will be instrumental in evaluating nursing programs in the future, following standards set by the Education Ministry and having sufficient authority and credibility to make an impact. Participation in this accreditation process will be voluntary.

In choosing employment, the nurses who participated in this study saw better prospects and more stability in a career in the public sector, but more opportunities to apply specialized knowledge and expertise in the private sector. Nurses fall into two groups: those who like their position because they enjoy what they are doing in their care of patients, and those who are not satisfied because they feel a lack of recognition for their work. The level of satisfaction of staff nurses was lower than that of nurses with management positions. This may be related to the rigid hierarchical structure of hospitals, which could make staff nurses feel powerless, for example, in expressing their opinions in the levels of hierarchy.

With respect to human resources, substantial differences were found between nurses working in the public and those in the private hospitals. The public sector has fewer nurses than the private sector do, with half the ratio of nurses to beds. These public sector nurses have less support from professional nursing colleagues and less support in terms of material resources than do their private sector counterparts. These findings were similar and consistent with an earlier study of working conditions of nurses and nursing aides in Chile (Hernandez & Weintraub,

1998). Overwork and questions of quality of work, responsibilities, and professional boundaries affect nurses in the public sector. The private sector has more nurses and better resources, both human and material, but often lacks clarity regarding roles and responsibilities. In this study, confusion regarding the limits of responsibilities of nurses and concern about who has or should have control over nursing activities have been found to be key issues.

The scope of practice of nurse participants in this study had two main foci: the care/cure of patients and the management of personnel. The roles of nurses and physicians appear more distinct in the private sector, where nurses are more involved in providing direct care to patients. In the public hospitals nurses are increasingly worried about management and assumption of responsibility for some curative functions and are less involved with the actual care of patients, which is delegated to nursing aides.

As a result, nurses themselves do not control their work well in health organizations. An individual decision to select a position is more related to market forces and bureaucracy than to a personal decision to find a well-paid position in a patient care area of specific interest. With the loss of nursing departments in all hospitals, and without clarification of roles and responsibilities, nurses are trapped in both health care systems, but in different ways, with jobs and salaries that are not always correlated with their professional training and qualifications.

In general, the employer controls the numbers and qualifications of nurses employed in hospitals. Nursing managers are involved to some extent in determining which nurses are hired. The findings in this study show that the satisfaction of nurses is more related to the nature of the work than the actual working conditions; that is, nurses are attracted to working in pediatrics, intensive care units, and emergency departments. Employment conditions are similar regardless of the speciality areas of clinical practice. In the private health sector, however, the tendency is to have more nurses with specialized clinical qualifications.

With respect to advocacy, the topic is controversial because nurses do little in explicit defence of patients. For example, in the private system, where nurses have adequate resources

and a ratio of 1 nurse per 10 patients, there may be a higher level of advocacy because patients are more demanding, better educated, and conscious that they are paying for services. In contrast, nurses in public hospitals, perhaps because of the lack of resources, the bureaucracy of institutions, and the politics involved, may be more likely to maintain the status quo than to advocate for patients' rights. There is no Chilean literature available on this topic, and more research in this area is needed.

Critical Analysis

Analysis of the degree of monopoly over the practice of professional nurses revealed deficits in terms of the actualization of nursing as a profession in Chile. The lack of licensure or standards of nursing care are of critical concern. Since 1997 nurses have been included in the Sanitary Code Law, which allows them to have an independent role and thus supports the possibility of nurses as independent practitioners. With this additional legal definition, nurses have become more conscious of their responsibilities in practice because they might be prosecuted for negligent activities (tort law). The leaders in this study concluded that the increased membership in CHNC is related to this increased accountability in clinical practice. It is a paradox that the legal space to pursue autonomous practice roles is perceived more as a risk than an advantage.

Nurses in hospitals provide nursing care, but nurses in the public sector also often have added medical duties. Under such circumstances their working conditions are risky, leading to overwork and stress from new functions for which they lack academic preparation. Nurse managers know that nurses may be placed in legally and professionally precarious positions, but they are not in a position of full power to discuss with authorities the legitimacy of the demands on nurses. Such discussions could produce conflict and tension between the nursing staff and the institutions. This appears to be a classic example of exploitation. Even in Western countries nurses,

> as members of a female-dominated profession, are constrained in the workplace, by the way work is organized on the hospital ward, by the allocation and control of resources, and by the product of their labour. Even if nurses are aware of their exploitation by the powerful administration they have few tools with which to change the process. (Breda, 1997, p. 105)

Even in countries where licensure and standards of practice are well established, "in nursing, power, status, and decision making control are more frequently determined by the institutions that employ nurses than by the mandates of the nursing profession" (Breda et al., 1997, p. 76). It would be of interest to do micro-level studies of nurses as they engage in practice in order to analyze power relations in health care institutions in Chile.

Although Chilean nurse managers declared in this study that they have authority in the health care sector, in terms of making decisions related to nursing practice, there is no objective evidence to support this claim. Advancement of the nursing profession, however, is difficult without clarification of the roles of nurses, including the delineation of boundaries regarding authority and accountability. Within hierarchical hospital structures Colliere's (1986) example is relevant:

> The whole health institution became ruled by a dominator-dominated system where doctors and administrators were only considered capable of decision-making while nursing personnel was deprived of any recognition and decision-making capacity although they had to do decisions in order to assure their service. (p. 103)

What happens is that nursing decisions are hidden and perceptions of the dependent roles of nurses become highlighted in institutional and social discourse.

It is clear that professional nurses in Chile have limited control over practice issues. From a feminist perspective, final decisions regarding conflicts and nursing demands within patriarchal hospitals are in the hands of male managers, traditionally roles filled by physicians. The ability of nurses to negotiate in the workplace is limited. Nurses do not have sufficient authority and power to claim adequate salaries. Although nursing is a profession, it is a gendered female profession, and social conditions prevail in which the most valued role of women is to be a mother and

machismo attitudes have stifled the development of nursing as an autonomous profession. Therefore, it is accurate to describe nursing in Chile as a struggle for actualization as a profession in which many members of the profession themselves refuse to engage.

Degree of External Recognition

External recognition is seen through the media, public perception, health-related institutions, and self-perception of nurses. The development of professional identities as nurses occurs in education and practice. Leaders who portray a positive image contribute in turn to the overall image of nursing. In this study the nurses in practice defined themselves as part of a middle-class profession working in hospitals. Professional nurses noted that society sees them as competing or blurred with nursing aides because society does not understand the differences between their levels of knowledge and education. The lack of clarity in their roles in a socially stratified society was mentioned as one reason for the poor status of nurses. In a stratified health care system, with its many different services and traditional hegemony of medical staff, care is perceived as less valuable than cure. Nurses' lack of recognition is related to a variety of factors: class struggle, gender, hierarchical organizations with a predominant medical vision, and, lately, a new focus on the attribute of beauty.

Status is also important; for example, when nurses choose positions, the prestige of the employing institution seems to be highly significant in their decisions on where to work. Such prestige may be inflated by propaganda, yet other benefits, such as the provision of meals and clothes, continue to draw new graduates. Marketing strategists in the private health sector are well aware of factors that enhance the recruitment of nurses.

Nurses in Chile have worn uniforms as a way to distinguish themselves from others. This has not been the best symbol to identify themselves as professionals because other hospital staff, except physicians, wear similar clothes. Moreover, white has become identified with female hospital workers. Whereas public-sector nurses are portrayed as bosses, those who give orders, in

the private-sector nurses are portrayed as connected with nannies, individuals who give comfort or basic care.

Nurses perceive that they do not have sufficient recognition as professionals compared to other health professionals whose societal recognition is equivalent. They also believe that they have more responsibilities than others because they are taking care of patients 24 hours a day and because they also manage personnel. Nurses would like to be equal to physicians, who are trusted more than other health professionals. These societal perceptions benefit physicians in terms of reinforcing their authority, which helps physicians to have a greater level of credibility in hospitals and in society. With respect to nurses as co-workers, physicians (as nurses believe) sometimes abuse their authority, which creates role conflicts. The nurses pointed out that before health reform they had better and more respectful relationships with physicians.

The participants in this study also described the relationships among nurses, with the 20-year generation gap, as problematic. Age-gap differences between younger and older nurses working in the same units, with few nurses of middle age as a bridge between the two, has had a negative impact on nurses. There are reduced numbers of nurses in the middle age group as a result of the closure of nursing education programs and fewer nursing positions in public hospitals in the 1980s in response to fiscal constraints in the public health sector. Leaders have labelled the 1980s as 'the lost decade' for nurses (Corral, 2002b). The age gap tends to limit collaboration and weakens nurses as a group.

In pursuing more recognition, nurses have two perceptions of themselves. First, in society nurses see themselves as barely visible as professionals, but with solid knowledge and an independent role separate from physicians that is not recognized. Second, in hierarchical organizations nurses see themselves as a divided group of nursing staff where the physicians are seen as the leaders, managers, and expert clinicians with authority. In the case of clients or patients, two variations were found. According to the perceptions of nurses in this study, patients in the public sector perceive nurses as the boss, and in the private sector as the nanny.

In the last decade nursing programs have been seen as one of the most attractive careers for new applicants at the university level (Luders, 2003). The findings of this study confirm that students in nursing programs in both the public and the private educational sectors are satisfied. University-level education is seen by Chilean society as a powerful way to increase social status. This interest in nursing is explained by the success of marketing campaigns to promote nursing programs in private universities, by the social recognition of work opportunities in nursing in the near future, and by the social value of nursing as reported by students who participated in this study. Nursing has been related to values of altruism and service to others. It could be that access to university education is expanding within the middle and lower classes, and nursing, with its opportunity for employment after graduation, is perceived as a higher status job by students from families whose access to higher education was limited in past generations.

Nursing's ability to effectively communicate professional contributions to patients, clients, managers, and the general public has been limited. The research participants believed that this happened because there are few nursing leaders and they are divided by different perceptions of what is a good image for nurses. When the nursing voice is heard, there is a perception that what is expressed is more related to individual political commitments regarding health-reform issues than to a true representation of the nursing profession. For example, a review of documents and photographs suggests that nurse leaders are portrayed as political activists (*"Derechos Humanos"*, 2003). Nurses would like to see leaders who capture and represent the full range of nursing interests. There is no recognition of nurses as a collective with a cohesive self-image. In this research the student nurses' main strategy to advance the development of nursing was to improve the nursing image through engaging the media in promoting the value of nursing work and the knowledge of nurses in clinical practice.

The development of the identity of nurses is complex and limited because nurses see themselves as professionals similar to other health professionals, but, in reality, their situation is different. For example, in the university educational system, nursing programs and faculty

members are at levels similar to those in other departments in other faculties. The schools and faculty members in nursing, however, are included mainly within faculties of medicine where academics and authorities outside of nursing consider that they should be. Documents that I reviewed revealed that there are no independent faculties of nursing in universities. In some new universities, nursing programs are included in health faculties, which can allow more room for nursing faculty members to make financial and political decisions regarding their programs. With respect to practice, the development of strong nursing identities is continually in conflict because nurses work in hierarchical health organizations such as hospitals where medical knowledge is the cornerstone of the system and where nursing knowledge is not always recognized. In undergraduate programs, nursing students are socialized in their learning process by nurse educators/instructors and nurses in practice. There is little or no practice-teaching integration, and students are exposed to conflict between nurses in education roles and those in practice roles. Issues related to advocacy of patients and powerful/powerless relationships in clinical settings are obvious, and the student nurses in this study suggested that increased autonomy in nursing is the best strategy for actualizing nursing as a profession. They would like to see a more professional attitude, one that is stronger and more independent. Nurses have few leaders in practice or in education. Throughout the years, with the social changes and political conflicts, nurses were not socially active; rather, they were silent, and few of them joined nursing organizations.

Traditionally, nursing leaders were managers or chairs of departments of nursing education with high prestige and good connections with practice settings. However, nursing leaders in the last 30 years have been more political activists than professional advocates. Contextual and historical factors in the evolution of the professional nursing organization have created a distance between nursing practice and education. Faculty members as leaders of educational settings and nurse leaders in practice are not united regarding professional issues and ways to address them. Chile lacks both nursing leaders who advocate for the development of nursing as a profession and nurses united in the pursuit of common goals.

Therefore, with the lack of professional leaders and the lack of clear roles of nurses in practice, the identity of nurses has been regulated more by external stereotypes in the media than by the professional group. Media images are powerful and are marketed through newspapers, television, and magazines. In this study the nurses complained about stereotypes in the media that negate their knowledge and expertise, and they perceived themselves as having no control over how they are portrayed. The current image of women as "perfect" and "nice," with "great beauty," is highly related to fashion and gender stereotypes. Nurses as women are identified as the "beauties of the hospitals." While visiting hospitals I saw pictures, flyers, and a variety of propaganda in which a nurse is typically represented wearing a white fancy dress, smiling, and giving comfort or information to patients. The message shows a woman using some basic tools in a hospital setting, but the main hallmark is beauty. The nurses complained about the most prevalent nursing stereotype: a woman in a white uniform who is using some nursing skills, perhaps with a syringe, and who is delicate and attractive. Because appearance is important in a consumer society, the image of women represented by the media as nurses or nursing aides is a sex-object stereotype. Physical attributes enhance status.

In general, nurses in the practice field saw that professionalism may improve through education in areas such as more advanced nursing programs and that more research and publication can help to create a better image of nurses as professionals. Faculty members also saw that more graduate programs can help to foster that image. According to the participants in this study, nursing associations must be involved in the promotion of more positive images of nursing.

Critical Analysis

Professions have a mission or a useful purpose in society; thus they can be rewarded with social prestige. Social recognition in the public sphere is of vital importance to professions and is related to competition for increased prestige, professional autonomy, and financial reward. In this study I did not measure the perception of the public, but the nurses offered their opinions on how

they believe the public view them. Through the lenses of nurses, they noted a lack of recognition from the public, physicians, and colleagues. Moreover, they saw distortion of their professional image related to confusion over who wears white uniforms, their positioning in rigid hierarchical structures in hospitals, and their portrayal in the media.

Nurses do not negotiate effectively in a consumer society, with its division of labor, that expects lower salaries for women's work. Moreover, the globalization of low wages in the new international division of labor is an important issue in Latin America. A neoliberal economic ideology leads to expectations of profit and thus regulates salaries in relation to market forces. This creates a tendency to pay lower salaries for women's jobs (Marshall, 1994; Mies, 1998). Nurses now have to deal with the consequences of market prices in their workplaces. Considering hospitals as places of production, the input factors are capital and labor, and nursing care is a factor of input classified as labor, according to neoclassical economic theory. According to Greenleaf (1980), "Wage (the price of labor) is taken to be equal to the marketplace value of a worker's marginal product, as the additional output produced by an additional worker" (p. 27). However, in the reality of a gendered division of labor, women's work does not receive equivalent salaries because the marginal product of women in comparison to men is not valued at the same level. In my opinion it is because of the double conditions of powerlessness: nursing as a woman's profession receiving a 'woman's' salary, and women as nurses not knowing how to negotiate their activities in workplaces. This is slowly changing as new graduates are becoming more aggressive in demanding higher salaries and better working conditions when they seek jobs.

In this analysis, critical and feminist theories are useful in uncovering the powerful impacts of images, messages, and symbols, which are used to keep people oppressed and subordinated. Latin America has not escaped the historical evolution of nursing images based on stereotypes of nurses as 'handmaids' and 'servile nannies.' Kalisch and Kalish, (1983) have been instrumental in delineating factors related to the public image of nurses in the USA and beyond. Moreover, in Latin America, machismo and motherhood need to be considered; both are powerful

beliefs expressed through symbols and images of subordination. Domestic roles of women are important cultural factors that have had significant influence in shaping women's issues and in the development of nursing as a profession. Key factors that have played a role in the recognition of nurses are public perception, physician-nurse conflict, motherhood, lack of leaders, nurses' conflict with nurses, and image and stereotypes propagated in the media. Each of these factors will be discussed briefly.

Public perception. Social class struggle from capitalism and gender struggle from patriarchy, both ideologies of domination, have intermixed oppressive forces in society and have been replicated in health care institutions such as hospitals, thus relegating women-nurses to the category of subordinates to men-physicians (Cleland, 1971). The longest traditional division of gender stereotype in health care organizations has been the relationship between nurses (women) and physicians (male), with the positioning of nurses shaped by traditional images of subordination: submissiveness, docility, and femininity (Lovell, 1981; McDonald, 1999). In general, stereotyped views of nursing emphasize subservience, lack of assertiveness, and domination of nurses, who are primarily female, by physicians, who are primarily male. Hospitals, as part of the patriarchal system, reproduce societal divisions where the structural hierarchy of relationships with physicians restricts nurses from creating a strong social identity or adequate self-esteem. From a feminist perspective of hospitals, "members of an underprivileged group who strive to join the more acceptable and privileged group developed a negative chauvinism toward their own group and thus deemphasized the underprivileged group's positive qualities" (Greenleaf, 1980, p. 34). This may be an important insight into the genesis of the acknowledged lack of unity in nursing. As Grey (as cited in McDonald, 1999) noted, "As a nurse and a feminist I find myself in the difficult situation of living in a culture that tends to promote an ideal model for women which guarantees the continued subordination of me as a woman" (pp. 34-35). In the Chilean case, machismo is an additional force that contributes to the condition of nurses as an "oppressed group," as Fulton (1997), Gordon (1992), and Roberts (1983)

discussed. In hospitals, because of these social hierarchical structures, nurses have had a long struggle with physicians in terms of roles and authority that, often passively accepted, has helped to keep public perceptions focused on nurses as helpers and not as equal professionals.

From a feminist perspective, for many centuries the division of labour in most societies made reproduction and care of people within and without the context of family women's unquestioned responsibility; thus nursing became an extension of women's work in the home to women's work in the public sphere. This 'unwaged labor' in the household is seriously contentious for women, because when "the assurance of availability of wage labor is increasingly threatened by changing economic conditions, the importance of unwaged labor to household survival increases" (Marshall, 1994, p. 36). As revealed in this study nurses as women workers have little access to mobility in their jobs because of children and other family obligations. In the private sector, legally, employers can fire employees with very few restrictions. Therefore, women constantly assume the dual careers of women because, as Kreps (as cited in Greenleaf, 1980) stated, "A large discontent with housework can surely be attributed to society's expectation that they meet this domestic obligation, regardless of the demand of their market jobs—a career constraint not imposed upon men" (p. 28).

Nurses' conflict with physicians. Chilean nurses have degrees at the university level just as physicians do. It is clear that prior to the 1980s there was imbalance and conflict between physicians and nurses; however, after the health reform of the 1980s, the increasing interest of profit in health markets moved physicians to a higher social position with access to better salaries and social recognition. As a consequence, physicians' work relationships with nurses changed from partnership in a team to a greater domination by physicians. Nurses perceived demotion in status to servants, nannies, or someone to take doctors' orders. Social class and gender domination were used to relegate professional nurses into submissive roles, perhaps to diminish their value in the marketplace, thus preserving a larger market share of financial reward for the dominators; in this case, physicians. The nurses involved in this study reacted in two ways: Either

they followed the (male) physician's rules with invisible work, submission, and feelings of powerlessness; or they became more aggressive and demanding, with their anger directed at physicians. This resulted in two poles of class and gender conflicts. On one side, some nurses would like a shift from the traditional doctor-nurse game to a new relationship "where one player [nurse] has unilaterally decided to stop playing that game and instead is consciously and actively attempting to change" (Stein, Watts, & Howell, 1990, p. 547). However, this strategy could produce more conflict because of the hierarchical nature of hospitals with traditional systems. On the other side, historically, in Western societies such as America, Britain, and Australia, the silence of nurses in powerless relationships with physicians has been used as resistance, but today nurses help to perpetuate the silence. As Lovell (1981) concluded, "Nurses have adopted the characteristics of their oppressor. Nursing silence can be profitable for the medical profession because a silent partner or team member is infinitely controllable" (p. 39). Each nurse has to face medical staff in different powerful/powerless ways. Unless the workplace changes, nurses may only have two choices: either to accept domination and work invisibly in silence or to leave the workplace.

Motherhood: Another important factor that has contributed to the lack of recognition of nurses is motherhood, an important role for women in Chilean society. Being a mother implies that nurses must do double work—in the hospital with medical staff and concomitantly with children and in the household. Both conditions may replicate unequal relationships: one from a physician who is higher in the hierarchy, and the other from the structure of marriage, where the husband enjoys higher status. When nurses are separated (divorce did not exist in Chile until 2004), they may have to support their children and raise them alone. In Chile, as in other Latin American countries, women who work often have domestic workers who are usually women. Salaries of nurses are decreased by that payment, and they are still the main economical and psychological support for their children. In Latin America nurses, like women in most contexts, are central to the family. The importance of women in the families is essential to harmony,

security, and development, both economically and morally; and Chilean women take this role very seriously (Valdez, 2000). The institution of the family is intrinsically linked to women: It is very important "to be a mother, wife and housewife and become socially part of the function of procreation, strengthening the ideal model in which home becomes the power domain of women" (Chompre, Assis Medina, & Christoparo, 1994, p. 650).

Lack of leaders: Social recognition is also affected by the paucity of leaders available to increase the public image of nurses. Without leaders in hospitals and universities, nurses and students lack positive role models. For example, the lack of positive nursing leaders in Chilean education and practice has resulted in managers or chairs becoming more administrators than influential leaders or visionaries (Alarcon et al., 2002). The few nursing leaders have been focused on political activism in the new democratic scene, activism that is the opposite of what the nurses interviewed in this study wanted. When nurses assume leadership in hospitals, they have to deal with powerful dominant groups, perhaps engendering conflict with the institution's rules if they complain or demand changes. Nursing leaders who advocate for nursing issues may not be perceived by employers as desirable for executive positions. For example, some institutions lack unions and have low salaries and poor working conditions, and leaders who were known to lure nurses to the collective bargaining table could be fired. Therefore, these situations reinforce less leadership for nurses and contribute to low recognition, low power, and poor image. As Freire (1970) contended, "The oppressed, having internalized the image of the oppressor and adopted his guidelines, are fearful of freedom" (p. 31); thus, prescribed behaviour patterns emerge. There are, however, also opportunities for new types of leaders in nursing, nurses who are less influenced by bureaucracy, 'the entrepreneurs' who seem to have fewer obstacles and more independence in their activities.

Nurses' conflict with nurses. Divisions have been created based on the ages of the nurses who work together. From a feminist perspective, it is probable that nurses who have worked in the system for a long time have allowed the patriarchal structure to permeate their work and their

attitudes, which has resulted in fragmentation or conflict as a group in the public health care system where different generations of nurses work together. This conflict has created a wide gap of understanding that separates nurses. In other words, perhaps some nurses have been forced to leave behind their true identity as women. As Ashley (1980) observed, "Many nurses [then] are deaf, dumb, and blind to the needs of women: nurses are often cruel and abusive to women and to other nurses" (p. 17). In this study the nurses in two different age groups reported difficulties working together. It is likely that nurses have conflict not only with other nurses, but also with students or nursing aides in clinical settings.

Images and stereotypes of nurses. The identity of nurses is hard to develop, and it is largely shaped by external forces, which stereotype women and therefore nurses. According to the findings of this study, the main external oppressive forces are social class and gender stereotypes that restrict identities of nurses as full professionals with the ideal image of *careerist*: "an intelligent, logical, progressive, sophisticated, emphatic, and assertive woman or man" (Kalisch & Kalisch, 1983, p. 21). Strong and constant images of nurses as submissive, hard working, beautiful sex symbols have made professional women's roles invisible (Muff, 1982). The use of uniforms, for example, has a strong impact in nursing. As Clendon (2001), a New Zealand scholar, affirmed, "Uniforms have been used as symbols of oppression by male and medical-dominated culture" (p. 147). Discussion of the appropriateness of uniforms as an identity of nurses has two contrasting dimensions: One group of scholars noted that uniforms help to identify nurses (Kelly, 1985), whereas other scholars were radically opposed because "[nurses] all get lumped together into a symbolic 'white army' of health care workers" (Martin, Martin, & Sangster, 1986, p. 33). In this research the participant nurses lamented that their uniform has not contributed to a positive image.

Therefore, external forces have seriously constrained the social recognition of nurses and camouflaged their work and daily realities through creating a distorted image of nursing. Society does not clearly understand the roles of nurses and the differences in roles and educational levels

within the nursing workforce. Freire (1970) described the concept of a culture of silence as the unwillingness of an oppressed group to speak out about their oppression either out of fear or out of hesitation to act out against an ideological alignment with management. This describes the nursing situation. Moreover, in pursuing social recognition and in being denied this recognition, nurses have turned their frustration toward members of their own profession. *Horizontal violence* describes a lateral lashing out of members of oppressed groups, because, "in reality, the oppressed cannot perceive clearly the 'order' which serves the interest of the oppressor whose image they have internalized" (p. 48).

Degree of Organization

Nursing associations play an important role in giving direction and collective support to nursing practice, education, legal actions, and issues affecting nursing (Ross Kerr, 2003). The Chilean Nursing Association (CHNC) functioned in a restricted way from 1973 to 1989, when Chile was isolated from the international political arena. Since 1990 CHNC has had an increased and more active presence in international activities. For example, it is now participating on the main board of the International Council of Nurses (ICN) and in the Pan American Federation of Professional Nurses (FEPPEN). This participation is important because it creates a more global network of nurses who can support the efforts of Chilean nurses.

Historically, CHNC was the exclusive nursing association and exercised control over its membership, registration, affiliation, ethics rules, and ethical codes for nurses. The power of CHNC was diminished in the 1980s when mandatory affiliation and registration were lost. At the university level the Chilean Nursing Education Association (CHNEA) perceives its mission as regulation and control over nursing education. Today, CHNC and CHNEA as the main voices of professional nurses have the following priorities:

1. To increase participation and influence in decision making on health policies and health reform.

2. To clarify nursing roles in practice.
3. To incorporate a nursing department in the structure of public health care organizations.
4. To improve the working conditions of nurses in public, private, and primary care health sectors.
5. To have mandatory registration for practice.
6. To control the accreditation of nursing schools and programs at the university level.
7. To increase affiliation and participation of nurses.

In general, in this study the main leaders of CHNC saw the priorities as related mainly to health reform (#1) and to professional issues (#2, #3, #4, #5, #7). In the short term (a) CHNC has to work at increasing the recognition of nurses by encouraging the rise of salaries and assisting in the clarification of nurses' roles, (b) the practice setting needs regulations through a legal structure that mandates licensure or credentialing of nurses in practice, and (c) nurses must create a new nursing culture as a group and work collectively for the same interests The CHNC leaders saw all of these points as achievable. In the longer term CHNC sees the enhancement of the status of nursing as a profession as a major challenge. To enhance status, the main thrust of CHNC is the promotion of more political involvement of nurses. Achievement of this goal will require greater affiliation of nurses in CHNC and collaboration with unions.

Priority #6 is being handled by CHNEA, as a consulting organization, with regard to providing guidance for nursing curricula in undergraduate and graduate nursing programs at the university level. CHNEA is becoming more influential through its participation in the National Commission of Accreditation (CONDA). Through that commission, CHNEA will contribute and have more control and authority to accredit nursing undergraduate programs. CHNEA expects that in the near future full accreditation of nursing schools will be a reality, more nursing graduate programs will be established, and research productivity in nursing will increase. Collaborative research is also seen as beneficial and may be stimulated through connections with universities

and programs in other countries. It is desirable to have more qualified nursing educators and researchers, and that should emerge with the improvement of graduate programs. The new doctoral program at Concepcion University in 2004 will develop new areas of research and contribute to the development of nursing knowledge. CHNC sees future research producing knowledge related to the quality of nursing services, as well as research based in clinical practice.

Priority #7 is related to providing support to the nursing student association (NSA), and leaders of CHNC saw this support as a priority. It is anticipated that encouraging student participation will have a positive impact on socialization into nursing and create a culture of participation in the professional organization. This study shows that students have low affiliation in the NSA. They do not perceive the importance of collective power, and perhaps they emulate the low participation in nursing associations that they see in faculty members and nurses in practice.

Nurses have low participation in both main nursing associations, and it is one of the issues on which nursing associations have been focusing. In the university educational sector, few faculty members and instructors are members of CHNEA. The findings of this study reveal less affiliation of faculty members in the private university educational sector, but the number of affiliates also depends on the local activism of the associations. Nurses in practice also have low affiliation with CHNC, although participation differs according to hierarchical positions in hospitals. Most of the managers and head nurses in the public health sector who were involved in this study are members, but none in the private health sector. Nursing staff are least likely to participate, especially in the private hospitals. Generally, nurses in higher positions seem to understand the importance of being members of the nursing association and of active engagement in the political process.

The findings from this study suggest that nurses are not affiliated in part because of a lack of interest in becoming politically active. There is strong political activism and participation of executive members of CHNC in many national protests and strikes related to health reform,

human rights advocacy, justice, and other political issues (Corral, 2003). The nurses in this study were divided into two camps: One believed that the political activities of their leaders do not represent their interests; the other saw the lack of democracy in the hierarchical structural of the nursing organizations as limiting meaningful participation of staff nurses. The political involvement of nurses in the new political climate of democratization is needed if changes are to reflect nursing's interest. It is likely that students' reasons for low participation are similar. They also cited lack of time, knowledge, or importance, and apathy to collective issues of the professional group as factors that make them inactive.

In terms of connections to other national associations, the involvement of the nursing association with different organizations, authorities, associations, and unions has developed intensively in the last decade. It was seen as a way of exchanging ideas and influencing the political decision-making process, but it has come at a cost. Many times this political involvement is not well accepted by nurses. For example, in the demand for better working conditions for nurses, CHNC has been involved in many rounds of negotiations, especially with the Ministry of Health, health professional associations, and workers ' unions; but the struggle has had a limited impact, and the power of the nursing association is sometimes diluted. Leaders of CHNC have worked actively in two ways: in coalition with other groups at a national political level and in nursing issues where leaders have concerns about the impact of health reform on nursing practice.

In the internal process of unification of the main nursing organizations, there is still a lack of integration among nurses in education and practice. A diversity of opinions from the two associations and in nurses' perceptions reveal a lack of trust of and cooperation with each other. Nurses in the MOH and CHNC exhibit a sporadic and not always trusting relationship. As a result, the nurses saw a lack of accountability in the associations and their leaders, but at the same time they are seeking support for greater professional development and social recognition.

Although in Chile CHNC has the mandate to assist in nurses' negotiations, the low level of affiliation has resulted in a lack of sufficient power to improve nurses' working conditions.

After the 1980s, legally, there have been three types of labour conditions with different laws, which dissipates power, especially in the private health sector where nurses lack unions and negotiate individually. The Chilean Nursing Association has had an important role and some success in creating collective support for nurses in the public health sector, and this support during different negotiations with the unions has resulted in some success. Moreover, in my opinion, a distant relationship between nurses in the private health sector and CHNC has developed. Where unions are not allowed, nurses can feel threatened if they show a desire to become affiliated with the professional association. Therefore, nurses in the private health sector may not want to be connected with any political association such as CHNC.

Critical Analysis

Participation in civil society through associations or collective groups has been limited under the structural, political, and neoliberal economic reform. Social movements and collective groups have had limits imposed on their power and ability to compel affiliation. In the case of Chile, society has moved forward slowly in the transition to democracy and participation. New networks of communities, groups, associations, and unions have built new types of leadership, but with scarce participation of citizens. Nursing in Chile is not unique in this respect; in general, nursing associations in Latin America have always have had few members. As Garzón (1991) noted, membership "in average is 20 and 30%" (p. 51).

From a feminist perspective, women in Latin America were one of the groups who were part of the political force and movements who participated against dictatorships (Baldez, 2002; Molyneux, 2000). After the transition to a new democratic society, women have had more limited participation in the political arena. Historically, women in all societies have participated actively in political conflicts against dictatorships, wars, and revolutions; but in a patriarchal society, after a while they are relegated to the private domestic sphere in roles such as mothers, wives, and housekeepers (French, 2002). In Chile, after the democratization process there were constraints

from political institutions that helped to reduce the impact of women as a politically active group. The Women's National Service Organization (*Servicio Nacional de la Mujer* [SERNAM]), as a Ministry of Women, was created to give more voice to women; but they do not have any political decision-making power (Franceschet, 2003). Nurses as women experience difficulty participating in democracy. Nurses are a fragmented group with no strong leaders to motivate action on collective issues. Finally, as women, nurses have double work with home and children as well as professional responsibilities, leaving nurses with a lack of time for other activities. As Gouthro (2000) asserted, "Women in all cultures assume most of the household work and childcare responsibilities" (p. 64). However, most of the nurses in this study who participate politically in CHNC as leaders are also housekeepers. Dual roles can be an excuse for inactivity in struggles that some nurses may not support.

Women in Latin America have been struggling in two different dimensions: One group struggles for the expansion of rights (class, race, ethnicity, sexuality, etc.), and the other group struggles, not for the expansion of women's rights, but for the preservation of women's traditional roles (Molyneux, 2000; Valdez, 2000). The tension produced between these groups creates divisions and weakens struggles for equity.

Nurses in the public sector who have an affiliation with unions and associations have had relative success in collective bargaining and negotiation. The neoliberal economic reform and its ideology of less support from the state do not allow much room to address issues of salary in the health public sector, such as in the last protest in 2003 when workers demanded a salary increase of 7% (*"Gremial,"* 2003). The Chilean Nursing Association has no control over nurses and employers in the private sector, and collective bargaining occurs in each institution depending on whether it is allowed or not under the Labour Code Law (*"Gremios,"* 1999). CHNEA is not too concerned with these groups of nurses because most of them are not affiliated and because of the lack of legal protection for workers in the private sector. More democratic structures in the

nursing association are needed to open up discussion of professional issues in an environment of equal dialogue.

Social reengineering has strongly impacted collective power in Chilean society. Nurses as a group of mainly women workers have been vulnerable to the effects of these reforms. Collective power of women and/or nurses is still in development, with the need and opportunities to create a greater culture of affiliation and active participation. Nurses understand the power of the collective well; however, they have less understanding of the etiology of the oppressive forces that affect their activities and their lives.

Summary of Issues Identified With Respect to Nursing as a Profession in Chile

The findings of this study indicate that there are 20 major issues inhibiting the actualization of nursing as a profession in Chile. Each issue is described briefly.

1. *No legal framework and lack of regulations*: There is a lack of legal clarity of the regulations regarding nursing education. Nursing schools are free to be accredited or not. There are some questions about how nurses are trained in the private educational sector regarding the rapid increase in the number of seats available for new nursing students without any mechanism for evaluating new nursing programs. Two situations could occur: The number of graduates could increase, but their competencies may not satisfy the health market demand for nurses; or the number of graduates could increase, but graduates may not meet the standards that the professional association wishes to enforce. At first glance it seems that the second scenario is occurring.

2. *Variety of curricula of nursing programs and lack of accreditation*: With 25 nursing schools in Chile and 49 nursing programs, some public schools have established minimum criteria for developing undergraduate nursing programs. Other new and emerging programs, mainly in the private university sector, have developed curricula, with a rough commitment to an

advisory role by professional associations. There are no mechanisms to ensure that advice and recommendations are followed.

3. *Lack of teaching preparation of new faculty members*: There are a limited number of qualified faculty members working in high positions and a tendency to find the more qualified faculty members in the public educational sector. With the fast development of new nursing programs in the last decade, few qualified faculty members and instructors are available. The findings of this study indicate that the private educational sector hires not only professional nurses with expertise and experience, but also new graduates with skills and the motivation to teach, but who lack teaching or clinical experience.

4. *Limited advanced nursing education opportunities*: Graduate nurses have different educational backgrounds. Accessibility and availability of degree programs are limited. Nurses in the public health sector cannot takes courses easily and obtain higher degrees because of the lack of financial support. The private health sector provides some funding and benefits for short courses and for visiting national and international units. Because of this dilemma, nurses have been obtaining the certificate/diploma, and there are few master's-degree prepared and specialized nurses. Few nursing graduate programs are available, tuition costs are high, and there is little financial support to allow full-time study. Nurses have made moderate progress in obtaining research funding, but more encouragement to publish research findings is needed.

5. *Lack of awareness of students about the quality of nursing programs:* Students in nursing programs lack knowledge regarding how nursing programs are different from or similar to each other and what the attributes of good programs are.

6. *The market of nursing education and practice*: More data are needed on how nurses are educated in the private educational sector and how the rapidly growing number of seats will impact the market. The health care sector has a high demand for nurses; however, standards for nursing positions are not clearly described and controlled by the nursing profession. Two concerns may arise in the future: The shortage of nurses may lead to a surplus of programs, and

nurses educated in these programs may flood the market. The creation of new programs should be related to predictions of supply and demand.

7. *Lack of clarity in nursing roles in practice*: Nurses are working with no definition of the roles that they should assume in practice. Their responsibilities include direct patient care, management of personnel, and, in the case of the public hospitals, some medical duties. Private hospitals have more explicit definitions of the roles of nurses; however, standards of practice and necessary credentials are not clearly defined.

8. *Lack of control over practice*: There is an absence of nursing departments in hospitals, and roles and responsibilities of nurses have been ill defined. In the public hospitals the nurses are confused because of added responsibilities related to new medical technology and treatments, and they lack the authority to control and define their practice. In the private hospitals the nurses are included more in management decisions relating to staff members. There is a need for more control, perhaps through CHNC, in defining and monitoring the legal scope of nursing practice.

9. *Lack of credentials for education and practice*: There is no uniform mechanism for the accreditation of all schools of nursing and no form of standard evaluation once nurses complete their undergraduate studies. Registration as a nurse is not mandatory for practice as a nurse, although graduation from a nursing education program is required. Approval of such programs is not under the control of nurses through CNHEA or any other mechanism, although nurse educators' involvement in voluntary accreditation of nursing education programs through CONDA is an important new initiative.

10. *Working conditions are varied, but salaries are similar*: Although nurses have varied working conditions in the public and private mixed health sector, their salary tends to be similar in all types of nursing positions. Determining which type of nurses is needed is defined by the rules of the market through advertisements and the promotion of benefits for nurses in the private health sector. The public health sector seems to offer the potential of a career, but the system is more rigid.

11. *Advocacy of patients or institutions*: The defence of the rights of patients is an issue that is likely related to the quality of care and number of patients per nurse. In general, patients are not well advocated for in public hospitals because of the limited resources in these hospitals. In the private hospitals the patients and families are more demanding of nursing services, and nurses seem to put more emphasis on responding to these demands.

12. *Lack of social recognition in society*: Nurses see themselves as having little recognition from society, health institutions, the health team, and patients. Depending on the social class and the type of health institution, nurses are perceived as bosses or nannies, two extreme descriptions that symbolically indicate a socially stratified hierarchy. Discrimination against women produces an image of nursing as mainly a woman's field, which results in devaluation in the market. Moreover, consumer ideology has included the idea of beauty as an attribute of women; and nurses, as participants in a gendered (primarily female) profession, have been affected.

13. *Lack of recognition from physicians*: There is permanent conflict in hospitals as hierarchical places of work. Physicians and nurses have a relationship that is not healthy for nurses, a relationship that sometimes involves abuse from physicians and in which nurses feel powerless. Some nurses maintained that physicians are the main leaders in the hierarchical organization in hospitals. In dealing with this relationship, sometimes nurses exhibit docile and passive behaviours rather than fighting for their rights and voicing their concerns. This situation carries an image of submission, one that dismisses nurses as professionals.

14. *Lack of control over nursing's image in the media:* The image of nursing as a profession is blurred by the lack of knowledge of society and by stereotypes such as "physician helpers" or "nursing aides." The Chilean Nursing Association does not have *a* policy about how to influence the media and control propaganda or offensive advertisements. Nursing images can circulate free of control and advice from the nursing association. The media portray stereotypical images of nurses and use traditional women's symbols rather than accurate depictions of nurses

engaged in professional work. Moreover, in a consumer society, media messages tend to link beauty in nurses to the prestige of the profession.

15. *Lack of leaders and empowerment of nurses*: Positive images of nurses as leaders of other nurses have been limited, and current leaders are often viewed negatively. Often, nurses perceived to have leadership potential, such as managers in institutions, are more involved with the bureaucracy than with building a professional identity. A new potential for nursing leadership is seen in the 'nurse entrepreneurs.'

16. *Limited development of adequate nursing identity*: With few nursing leaders in education and practice, weak nursing identities have been developed. Students have perceived strategies for enhanced professional status through a "better professional attitude" as the way to stronger identities in practice and education.

17. *Lack of affiliation of nurses with associations:* In the educational system, nurses lack motivation to become affiliated with associations; most nurses do not see affiliation with their professional organizations as relevant. However, under the new legal process some nurses feel vulnerable and see this increased vulnerability to litigation as a good reason to become members of CHNC. Because many do not belong to the professional association, it is difficult to estimate the number of nurses in active nursing practice in Chile.

18. *Lack of active participation of nurses:* Active participation is another issue for those who are members of the professional association because they are still an invisible force within the nursing organization. The issue of lack of active participation in terms of being heard, having opinions, and making decisions as part of a group is prevalent in the new Chilean society. This lack of participation is particularly evident with women. Individual apathy has meant that nurses expect somebody to guide them, and invisibility rather than political involvement has been predominant in the nurses' group. Moreover, it seems that nurses do not recognize the relationship between participating in professional associations and building a strong professional identity.

19. *Employment conditions with lack of success in collective bargaining*: Negotiation between nurses and hospital organizations is strongly dependent on the institutional sector—public or private. In public hospitals nurses can negotiate through unions or the nursing association, but in the private sector nurses negotiate more individually. Hence, their abilities to negotiate are weak. Private hospitals and, in general, the private sector do not want unions and collective bargaining in their institutions.

20. *Legal prosecution of nurses in practice:* Nurses have been alarmed by the new circumstances of legal prosecution against some nurses in practice. Under the Sanitary Code Law of 1997, nursing is recognized partly as an independent profession. At the same time, the lack of a clear scope of practice may put them at risk legally. Nevertheless, that issue has produced more recognition of the need to become members of the professional association than any promotional campaign could ever achieve.

Reflections on the Four Dimensions of Professions: To What Extent Is Nursing a Profession in Chile?

The criteria used by Turner and Hodge (1970) were useful in analyzing the nursing profession in Chile through four dimensions considered to characterize professions. The use of social and feminist theories allowed exploration of some of the forces that limit the development of nursing as a profession. More specifically, examining Turner and Hodge's four dimensions of a profession enabled me to attempt to answer the question regarding the extent to which nursing is a profession in Chile. The findings show that nurses believe that there is a body of nursing knowledge but that they have a difficult time identifying what it is. Nursing research is in its infancy, but the development of new graduate programs may bode well for the future. There are no common standards in nursing education, and, although accreditation is developing, it is limited to some public universities. Because membership in the Chilean Nursing Association is not mandatory, few nurses belong to it, and fewer participate actively in nursing organizations. The

data from nurses who work in hospitals show that there is no clear scope of practice and that the structure of hospitals does not include nursing departments. It can be stated that nurses have limited control over their professional activities. Social recognition is also limited. The image of nurses is blurred by the multiple roles in practice and associated with themes of social class struggle, hierarchical positions, gender and womanhood roles, and stereotypes of women.

In the Chilean mixed health care sector, it appears that nurses have little autonomy and recognition. Three key barriers can be identified. First, the external changes created by the social-economic reforms have had a great impact on the health and education sectors as well as on the professional associations. Second, the perpetual struggle with physicians and the bureaucratic structures of hospitals have contributed to the low social recognition of nurses and to the limited ability of nurses to influence the system. This situation can be extended to the educational sector, where nursing programs and schools have been located mostly in faculties of medicine. Third, nurses themselves seem to have limited their career development by conforming with social norms and having limited participation in professional activities, with few leaders emerging from the nursing ranks.

Chilean society has changed structurally, and health and educational reforms have included increased privatization. Unfortunately, this system continues to limit the control that professional associations can exert. Nurses also have limited access to unions and collective bargaining. Concurrently, society has a persistent image of nurses as physicians' aides. Professional nurses have also been affected by the social constraint of being women workers in a patriarchal society.

Positively, there are signs of improvement through changes for professional nurses such as the independent role under the Sanitary Code Law, recognition of the need for more undergraduate and graduate nursing programs, and the forthcoming creation of a legal framework with nursing authority over registration, licensure, and accreditation. Development in these areas

will lead to better control of professional issues and will strengthen nursing associations. When these issues are resolved, Chilean nurses can aspire to greater levels of autonomy.

Understanding the sociohistorical context in which nurses were and are seen as workers and women may help nurses to recognize that they are an oppressed group. With regard to the persistent constraints of patriarchy and the hegemony of social class divisions, nurses' consciousness must be raised so that they have a clear understanding of the forces that have limited their freedom. Therefore, nurses in Chile are engaged in a process of professionalization within the constraints that have been noted. In the next chapter I use social theory relating to professional power and empowerment to explore the potential usefulness of this research.

CHAPTER 9:

PROFESSIONALIZATION OF NURSING IN CHILE: THE WAY FORWARD

This research has demonstrated the constraints encountered in the actualization of nursing as a profession in Chile. Concerns raised focus on issues of limited professional autonomy and social recognition. Nurses face internal and external challenges at individual, family, professional, and societal levels. These multilevel challenges intersect in ways that constrain but also provide opportunities for nurses, thus creating possibilities for change. Understanding postmodernism, as well as poststructuralist and feminist perspectives, offers guidance for the way forward. The multiple contexts in which nurses in Chile are struggling to achieve greater autonomy are explored in this chapter.

The Relationship Between Professional Autonomy and Power in Nursing

As the literature presented in Chapter 4 demonstrates, Latin America, as well as other countries throughout the world, underwent political and economic structural changes in response to Word Bank and International Monetary Fund policies during the 1980s. The relationships among professions were affected. For example, Mishra (1984) reported that the restructuring of work in the health care sector accompanied the advent of neoconservatism in Britain and the USA. In Canada the provincial governments (especially in Alberta and Ontario) demonstrated a populist shift from the collectivist ideals of the postwar years (*Keynesian*) to a free-market ideology (*laissez-faire*), within which individualized ideals of self-care, individual responsibility, and the decline of the state are key (Mishra, 1990). Evidence suggests that most countries in Latin America have had limited autonomy to decide their future. These reforms, related mainly to increased privatization of formerly public services, have affected the structure of work and the autonomy of professions in many countries; the effects on nursing in Chile have already been

discussed in previous chapters. Autonomy in nursing will be described in terms of positioning within professional and social hierarchies and nursing as a gendered profession.

Professional Positioning

Professional autonomy has long been a dream of Latin American nurses. The context of nursing as a profession is mainly a position of lack of political influence in contributing to decisions relating to health and education reform. In the Latin American region, nurses lack control of their own activities because others, such as politicians, economists, managers, and physicians, have historically decided nursing issues (Colman, 1990; Manfredi, 1983).

Professional autonomy exists when the professions define and regulate the nature of the services offered through control over recruitment, licensure of members, and creation and monitoring of standards of practice. Therefore, to determine whether nursing is a profession, it is useful to ask the question, What is the full spectrum of nurses' control of activities in practice and in education? Chilean nurses who participated in this study work in hospitals where there is no nursing department to ensure that nursing practice is independent of the other activities or roles. Nurses do not have role clarification over practice to ensure nursing expertise over care, and they do not have a legal requirement for professional licensure to ensure a minimum standard of competency. Nurses lack the authority to control quality within nursing education programs through their associations, and 50% or fewer of their members are affiliated with the professional nursing organization to ensure collective power. Thus, it is reasonable to assume that Chilean nurses are not at this time part of an autonomous profession. Nursing autonomy must "include accountability, empowerment, and commitment to the profession" (Holland, 1999, p. 312).

Historically, the nursing profession lacked prestige or autonomy because issues of power and self-governance were dominated by medical hegemony in the health care system. Today, however, the social stratification of professions is in flux with high market competition, and the mobilization of professions with the concomitant social recognition depends on issues of supply

and demand. Professional activities are regulated more by market forces than by professional organizations. Hence, what professions have won or been given can now be lost or expanded.

Larson (1977) noted that "the market is not passive, that the structure of the market in which a profession transacts its services does not depend on the professions' action and intentions—or at least not until the profession gains considerable social power" (pp. 17-18). The new Latin American social order has put less power in the hands of the state and more influence from markets for services and products needed to satisfy the population. Professionals and their social power, as reflected through their prestige and autonomy, have varied. Some of them have lost power as others have gained it. Not only are professions driven to increase their influence over others, which results in public recognition, but also professionals focus, as Brown et al. (1987) suggested, on "a relative control of market price" (p. 212). Larson believed that aspiring to social recognition includes control over educational and normative regulations. In this new social-political-economic scene, it must also include political influence because professionals want access to market gratification such as prestige and power, and they compete with each other, primarily as a mechanism to achieve personal and professional goals.

Contemporary nursing in Latin America has changed, and other countries show a similar trend. In a study of four countries in Latin America and the USA, Guevara and Mendias (2002) noted:

> There are changes in the labour market, changes in nursing workforce, flexible employment contracts, discrepancies among educational preparation and roles in work places, and malpractice concerns because of lack of credentials. The nursing labour market reflects economic trends across these countries to varying degrees. (p. 352)

Thus, the effects of health restructuring noted by Guevara and Mendias are reflected in terms of Chilean nurses' working conditions, roles, and responsibilities. As Alarcón et al. (2002) have found regarding Chilean health reform:

> These changes have generated an important discussion in redefining the professional role to adapt to both the highly technical competitive environment and the demand for

> increased efficiency at the lowest cost, while at the same time, keeping a holistic vision of patient care. (p. 336)

Moreover, when professional autonomy exists, as Larson (1977) suggested, there is often conflict with bureaucratic authority. Findings show that nurses' conflict regarding professional expectations of autonomy is related to salary increases and better working conditions at the centre of their struggles. Bureaucracy in hierarchical public hospitals, characterized by levels of authority and a high division of labour with rules, procedures, and classification of work according to technical competence, ensures an inverse relationship between professionalization and bureaucratization (Engel, 1970). In the public sector in Chile bureaucratic managers are well supported by nurses, who work passively and invisibly without much involvement in nursing associations. In the private health sector the system is less bureaucratic, but nurses have lower unionization or collective identification with professional issues. In both the public and the private health care sectors nurses do not challenge authority. According to the participants in this study, nurse managers, administrators, and faculty in public and private health care and educational institutions are more involved with organizational affairs and policies within their institutions than with issues of professional collective interest.

Chilean nurses' affiliation with the professional organization, which would allow them to maintain "a sense of identity, colleague loyalty, and shared values" (Johnson, 1972, p. 55) over a long period of time, is low. It is estimated that more than half of the 8,000 active nurses in Chile (Luders, 2003) are not members of CHNC. After more than two decades of voluntary affiliation, the Chilean nursing association is not working with all nurses. This lack of affiliation means that nurses are not a strong collective force who could exert power and influence in the political arena. Nurses perceive their professional association as having a weak voice, few leaders, and limited loyalty among colleagues. Dissimilar values emerging out of what could be a powerful collective identity weaken the position of nurses in Chilean society.

Nursing as a Gendered Profession

Perhaps deeper influences on nursing as a profession can be analyzed through a gender lens. The undervaluing of women's work is a perpetual problem (Coburn, 1999; Witz, 1992). The nursing profession is comprised mostly of women, with 95% of nurses in Chile being female, a percentage that is reflected in many other countries (Guevara, 2002; Souza, 1990, Stiepovic, 1998). From a feminist perspective, the structures of patriarchy and machismo beliefs, both ideologies which continue to surround and oppress women and women workers, have had two conflicting effects on nurses. One is that nurses feel powerless and react with silence, passivity, and perhaps horizontal violence to other nurses; the other is that nurses feel powerful but demonstrate the same behaviours as the dominators (Bent, 1993; Freire, 1970; Roberts, 2000). The often powerless relationship with physicians in the health care system can intensify gender imbalances by adding dimensions of social class and professional hierarchy. Gender conflict within rigid health care environments such as hospitals limits nurses not only in their working environments, but also in their private lives. As mothers and wives, nurses encounter similar patterns at home (Gouthro, 2000). The findings in this research are clear: Nurses feel constrained and oppressed under physicians. With the lack of influential nursing associations and leaders, the development of positive nursing identities is difficult.

Professional nurses in Chile were part of the struggle of women, with their active political participation through their nursing association, in the decade of the 1980s. This past political activism attests to the collective power that nurses had in the turbulent period of dictatorship. Today, however, nurses scarcely pursue collective goals; and, what is more alarming, they deny and reject most collective action. As a result, they have become fragmented and divided, struggle with each other, have less political impact, and have become powerless as a group. Autonomy as a profession is improbable in such conditions.

Societal Positioning

Status or recognition, as the other reward besides autonomy in the market stratification of professions, has not benefited nurses. As middle-class professionals—as nurses are referred to in society—they have been influenced by different external social patterns in Chilean society. In the class struggle in society, nurses as part of the hospital team are seen with no clear definition as *professional*. This aforementioned notion is mixed with a higher vision of physician-males in the dominant role within these institutions and with the political leverage exerted by different health professions. Stereotypes and images of nurses are usually those of *female/beauty* helpers for traditional paternalistic physicians in hospitals, thus hindering a more positive professional image of nurses. Although nursing uniforms are usually seen as symbols of professionalism for nurses, they are unlikely to portray professional status within Chilean society because other workers with no claims to professional status also wear similar uniforms. From a feminist perspective, the social status of professional nurses as female workers is not evident. Nurses are viewed more often as assistants/helpers in delivering health care and are firmly linked to the gendered division of labour and the gender stereotypes. Thus, female roles exist to help keep that status quo. The mothering role produces a dichotomous option for many nurses, one that helps to retain a high level of responsibility in the *rearing* of children in conflict with the development of a professional identity within their careers. Multiple, co-existing, and equal identities for women are not yet possible in this social milieu.

The nursing profession is perceived by Chilean nurses as a middle-class profession in a society that has experienced new social class tension after reforms. Public and private health care and educational sectors moved at different paces and with different purposes, which increasingly affected nurses' control over their domain as a professional group. The new scenario has opportunities and barriers. For example, free-market competition has opened new challenges for development of standards and measurement of the quality of patient care. The private health care sector has generated more and more diverse job opportunities for nurses with a vigor that has

stimulated the creation of more higher-education opportunities to prepare nurses to meet the challenges. Less positively, the private health care sector has more influence over health professions through an ideology in which profit and activities are seen not as services but rather as "commodities" that are regulated by the needs of the market. Thus, nurses are affected by the focus on efficiency, cost-benefit analysis, and patient satisfaction indicators, and nursing care is not always recognized as a valuable contributor to health outcomes.

This research on nurses in Chile suggests that aspirations for more progress in the professionalization of nurses have been constrained because they have lost control over the regulation of nursing practice and education. Societal distinctions related to gender, class, and professional hierarchies provide partial explanations. Application of postmodern, poststructuralist, and feminist theory can enhance understanding.

Contribution of Knowledge of Postmodernism to an Analysis of Nursing as a Profession in Chile

Postmodernism is a complex phenomenon in which societies are seen as eclectic, with multiple realities (deconstruction of reality), in a fragmented time, with a series of perpetual presents. Postmodernism has influenced intellectual thinking in nursing and other disciplines as "more constructivist, critical, and interpretative frames of complexity have led to disownment of theory or a dominating system that restricts human liberation and evolution" (Watson, 2001, p. 301). For example, Reed (1995) reported that nursing is being called on to critique its own worldview and return to its core values, philosophies, and theoretical metanarratives, where "theory, then, does not represent truth, it creates truth" (p. 75). The nursing discipline must stop using inadequate frameworks such as biomedical and economic models. A 'situation-specific theories focus' incorporates more social and historical context, as well as specific time and social-political constraints on outcomes. Such a focus leads to findings that are congruent with the

nature of nursing as a human science and provides a better framework for generating nursing knowledge (Meleis & Eun-Ok, 2001).

In the case of nurses in Chile, the dilemma of the *technology* of care versus the *humanism* of care is seen with mixed influences and different purposes within the public and private health sectors. This is important because nursing education with its variety of nursing programs has the potential to create new designs of curricula that can address multinarrative worldviews. Postmodernist values come from the realities of culture and the context of everyday life experiences. As Reed emphasized, "Nursing practice is regarded not only as a place of applying knowledge, but also as a place to generate and test ideas for developing knowledge" (p. 79). Finally, with the diversity of contexts within which the nursing profession is practised, the metanarratives of each health reform could be useful for the development of nursing knowledge. This is particularly true with situation-specific theories that "focus on specific nursing phenomena that reflect clinical practice and that are limited to specific populations or to particular fields of practice" (Meleis & Eun-Ok, 2001, p. 882). Postmodernism, with space created for the existence of multiple realities, offers the possibility of in-depth analysis without the loss of complexity that often occurs in other theoretical approaches.

Perspectives on Poststructuralism and Power in Nursing in Chile

In critical theory power is interpreted as oppressive, coercive, or dominant. Deveaux (1996) referred to oppression as "the relationship in which one wishes to direct the behaviour of another" (p. 222). Foucault's (1976) definition of power, in contrast, suggests that all social interaction is defined and thoroughly permeated by the exercise of power; power is always present. Moreover, power, in its relationship with knowledge, begets knowledge and can be seen as a positive force. Foucault saw power not only as "residing" in individuals or groups but also as an intricate web of power technologies operating through society. Therefore, he perceived power

as operating as a productive force and not only as repressive and therefore cautioned about analysing power from a singular perspective.

Thus, in accordance with a feminist position in a nondominated world, one could not go into fatalistic views about the "omnipresence" of power as in Foucault's (1976) vision. In that sense, I agree with Heckman (1996) and other feminists who identified what feminist theory does that Foucault did not do: "to look critically at the issue of freedom where it concerns women's responses to structural inequalities" (p. 223). Based on the premise that the analysis of power involves understanding forces of domination, Allen (1996) assumed an "oppressive power-over relation" (p.267) and described levels of power as follows:

1. *A micro level of power*: This refers to the "forces" of personal relations between one individual and another individual or group, which Foucault (1976) called the *micro physics* of power. One example in the Chilean nurses' case is the power relationship with physicians every day that some interview participants viewed as abusive. Because power operates locally to circulate and emanate in legitimate or illegitimate micro-power practices, local narratives can be used to analyze power relations in clinical practice. As an example from this research, the nurses perceived imbalances in power relationships with physicians that are manifested in dialectical communication through messages expressed in tones of voice that display power differentials.

2. *A more macro level of power*: This refers to the *circulation* of power, as, for example, with *cultural* discourses or meaning. The Chilean nurses could see the cultural meaning that reinforces oppressive power relations in practice; for example, nurses as women are addressed in the workplace as ' Senorita' or 'Maria,' in contrast with physicians, who are addressed as 'Doctor' in recognition of their status. In the case of *social* practices, Allen (1996) described "the continuing transformation of power relations that cut across divergent institutional contexts" (p. 274). The use of regulations and rules perpetuates the surveillance of some professions but not others. For example, a good nurse in the practice setting in Chile is ***"someone quiet, passive, and hard working!"*** Status differences are reinforced when personal characteristics take precedence

over professional competence; for example, in hospitals, where only the physicians are allowed to raise their voices and nurses are controlled by their own silences. Hospitals are public spaces where societal power structures are reproduced. Nurses can benefit from the realization that hospital structures perpetuate power over others and that organizational structures are not passive but have their own techniques and mechanisms of domination.

Although useful, Foucault's (1976) analysis of power does not explain the metapower of domination. The inconsistencies of how power and repressive forces interplay to constrain aspirations to emancipation are not adequately addressed (Allen, 1996; Deveaux, 1996; Gilbert, 2003). As Allen (1996) declared, "His [Foucault's] account of power is insufficiently structural to do justice to the power relations that affect and, to some extent, define the lives of women" (p. 279).

Foucault's (1976) analysis is still useful for nurses because it provides opportunities for understanding the micro-politics of power. For example, Gilbert (2003) demonstrated, through analysis of texts and interviews with professionals working with persons with disabilities in health care services in the UK, "how discourses of normalization and the use of the contracting process has produced and disseminated a discourse promoting the benefit of the 'supported living model'" (p. 45). In an other example, Du Plat-Jones (1999) pointed out that "self-representation and representation of nurses can enhance or weaken their images and the subsequent power they have in society" (p. 42). Discourse analysis can display how power is at play in different contexts, as well as the ways through which it is expressed. Secondary discourse analysis of the data in this research could provide such evidence and may be useful for future research.

Implications of Feminist Perspectives of Power and Empowerment for Nursing in Chile

As this research shows, Chilean nurses have been affected by external forces, but social critique and self-reflection on the social inequalities are not sufficient without including gender

barriers within the cultural setting in Latin America. I assume a critical feminist position when I examine nursing as a women's profession in an oppressive capitalist system.

Feminist theorists have argued that gender is a social construct, one that is designed, implemented, and perpetuated by social organizations and their structures, rather than something that is merely true and accepted as innate. In this affirmation, feminist theory provides two very important awarenesses. First, when feminist theory separates the social from the biological, it sees gender as a product of human ideas, and hence something mutable and changeable. The second is related to the first: by separating the social and the biological or the constructed and the innate, feminist theory insists that gender is not something 'essential' to an individual's identity (Butler, 1989). Both dimensions are important to connect with gender social construction in both the workplace and the home. Hearn (1982) declared:

> The oppression of men is capitalism; while women are oppressed twice over: both by capitalism and by patriarchy. Capitalism operates by the wage of labour to value and profit; patriarchy operates by the appropriation of the unwaged labour and energy of women to produce male power. (pp. 187-188)

Therefore, viewing power and empowerment from a feminist theoretical perspective is useful because it supports the idea that the nursing problem is a women's problem and situates nursing in Chile within both *gender* and *occupational power* frameworks. Notions of empowerment will be described from two perspectives: empowerment of women-nurses and empowerment within the politics of care. Both perspectives are intertwined and synergistic, thus revealing both barriers and opportunities.

Power from a feminist perspective is a social and political phenomenon, and empowerment is associated primarily with the exercise of power to generate spaces of liberation. Different conceptualizations of power, including discussions of which prevalent type of power is convenient for nurses, are abundant in nursing literature; most publications emphasized administrative perspectives (Laschinger & Havens, 1997; Wilson & Laschinger, 1994) or social psychological theoretical perspectives (Rappaport, 1984; Thomas & Velthouse, 1990). From a

critical social perspective, "power is clearly one element in all social relationships and is difficult to separate from such related concepts as authority, control, influence, and domination" (Stacey & Price, 1981, p. 3). Empowerment also has a variety of meanings, but from the feminist perspective, empowerment "is a process of transferring power and includes the development of positive self-esteem and recognition of the work of self and others" (Rodwell, 1996, p. 310).

In a patriarchal vision of the workplace, such as hospitals are for nurses, institutions are seen as oppressive; and perhaps some nurses have assimilated the values and adopted the behaviours of the oppressors, such as physicians and managers. Nursing is integrally related to the central concept of care. According to Cloyes (2002), care is central to nursing theory and practice, and "care is located at the nexus of gender and power" (p. 206). This implies that nursing care cannot be separated from nursing power. Nurses, however, may feel uncomfortable with power because it is usually related to masculinity and "strength, aggression and independence, and it is related to having control over others and nature" (Falk Rafael, 1996, p. 6). Nurses, as mainly women, have been labelled with feminine attributes; and thus, if they want to acquire power, they often must distance themselves from other nurses and become marginalized (Robert, 2000). But Falk Rafael (1996) commented, "Power, at this layer of the dialectic, is still only available to nurses by assimilating male and medical norms" (p. 11). There are nurses who decide to acquire power in the process of seeking autonomy and recognition, but the cost of power gained for nurses in this way can be professional disunity and lowered individual self-esteem.

The best indicators of power are seen at the level of the public sphere and are related to politics, policies, and decision-making affairs. Nurses must increase their power within the health care system through a critique of that system, which is part of the structural hierarchical model of inequality. As Stevens (1983) advised, it "is an imperative for nurses to exercise [power] in order to realize their full professional potential and maximize their contributions to health care and society at large" (p. 3).

Women in politics, according to Sapiro (1983),

> are evaluated by two different standards: first the standards of femininity, and second, the standards of politics, non feminine and superior to the feminine. It is expected that the actions of women are derived from their central private concerns of wifehood, motherhood, and homemaking. (p. 7)

From a feminist perspective, pursuing power in nursing could be assumed to be a political commitment, because the division of labour brings sexual politics, and the care versus cure dichotomy brings the politics of the right to care. Thus, it is assumed that not only the subjects as nurses must be empowered, but also the object of nurses. Therefore, the empowerment of caring and the consequent enhanced social status of caring activities are closely connected with the empowerment of nurses.

There is a historical and inherent conflict within nurses in their relationships with power (Falk Rafael, 1996). Nurses "may feel this discomfort more acutely because they are predominantly women and have not been socialized to exert power and because caring is considered central to their practice, yet is perceived to be incongruent with notions of power" (p. 3). *Politics*, understood by Mason, Talbott, and Leavitt (1993) as "the process by which one influences the decision of others and exerts control over situations and events. It is a means to an end" (p. 6), is seen as highly influential in the allocation of resources. *Policies* are seen as "the principles that govern action directed towards given ends; or directed toward some end " (Titmus; as cited in Mason et al., 1993, p. 5). This study provides the fundamental opportunity to articulate two dimensions of nursing and care: politics and power. Thus, an empowerment model with political involvement of nurses, as Des Jardin (2001) suggested, "offers many opportunities for nurses to become political activists. Involvement at community, professional, and institutional levels is a base for action that provides significant public education and demonstrates the importance and versatility of nurses' roles in public concerns" (p. 624). Nurses' responsibility to use their unique knowledge and insight to influence health-policy decisions is related. Recognition at the political level is likely to foster involvement at the policy level. Conversely,

involvement at the policy level could also stimulate recognition at the political level. Nurses could benefit from powerful champions who could provide entry into the policy formulation arena.

Universality of Issues Related to Women/Nurses as Professionals

After extensively reviewing the nursing literature from countries and regions such as the USA, UK, Australia, Canada, South Africa, and Latin America and integrating this research on Chilean nurses, I have concluded that there are common general nursing issues. Many of these common issues are, at least in part, women's issues. This research shows the relevance of the Chilean voices and problems from a feminist perspective. Miller (1998) identified universal issues relating to women: The personal is political, invisibility, marginality, feminist consciousness, and the division between leadership and constituency. Each of these points will be discussed briefly.

Personal Is Political

The relationship between the personal as an intimate experience and the social and political is not individualistic or isolated. Thus, as a female-dominant profession, nursing is subject to those socio-political forces that have undermined feminine values in society. In this period of many radical changes in Chile, nurses as part of the delivery of health care services have lacked a voice in the public arena. The literature on nursing throughout the world reported that women and nurses often do not participate actively in social politics. This study revealed that more than half of the nurses interviewed or surveyed do not participate in nursing associations. In addition, the nurses perceived that society is not aware of their expertise. Therefore, nurses must use the power of politics and become advocates for themselves and for their patients. The caring function of nursing needs to become as important in public discourse as the curing function of medicine.

Invisibility

Historically, women's experiences, voices, and words have been invisible. Systematically, the patriarchal system has made social exclusion of women from the public sphere common and has reduced their place to a private one, such as home, family, and rearing children. Invisibility as a universal issue of nurses/women is perpetuated because nursing is a predominantly female profession within a society that undervalues care as 'women's work.' Nurses must make the caring visible through campaigns and propaganda using appropriate language, symbols, and positive images.

Marginality

When a person lives in two worlds, but one side of the world is perceived as more prevalent and normal, then marginalization is part of the description of two simultaneous realities. Hospitals today are seen as places of male-medicine-manager-domination, where "nursing' s marginal status is the development of care modalities that are unspoken, unrecognized, and unappreciated by the dominant groups" (Muff, 1982, p. 179). In this study the nurses claimed that accepting marginalization is the way to survive in the system. They contended that nurses must work "in silence, [be] submissive, and work hard." Therefore, strong leadership from all levels is needed to reverse the marginal status of nurses through either resistance or a shift to increasing democratization of the workplace.

Feminist Consciousness

Feminist consciousness is a legitimate way of understanding nursing realities and ways of knowledge generation and utilization, which cannot be separated from personal experiences of individual nurses as women. As Donovan (1985) claimed in her depiction of feminist consciousness, "It is necessary to establish a clear theoretical idea of what constitutes a woman's world, their culture and values, and how these relate to women's historical material base" (p. 172). In this study the Chilean nurses lamented that the care-knowledge relationship is not

valued and recognized. In education, the students asserted that nurses must stand up and faculty members must advocate for more development of graduate programs. Nurses in practice wanted more recognition of expertise and unique roles.

Division Between Leadership and Constituency

The fragmentation of nursing leaders and potential leaders has been an important conflict issue in nursing everywhere. In education, practice, and administration, nursing leaders have always had internal power struggles and consumed energy to solve them. There is little connection between leaders from one nursing field and those from another, and the Chilean findings show a lack of common strategies for achieving similar goals, especially between academics or administrative nursing leaders and leaders within nursing associations. There is a need for integration and professional loyalty of nurse leaders allied with the development of the skills needed to build nursing constituencies that work together toward common goals. Necessary leadership traits include "credibility, passion, and value of the nursing profession, as well as self-confidence" (Upenieks, 2003, p. 140). Leaders of the future need to have a balance of two things: loyalty to the nursing profession, but also credibility within health organizations. We need nurses who are "skilful in communication, collaborative, coaching, and guiding rather than directing, and who [also] can put in place the infrastructure needed for a productive organization" (Shaver, 2001, p. 940).

These five universal issues are applicable in the Chilean nursing context and can be applied in each country where nurses work. Attending to country-specific issues relevant to each dimension could provide a template for energizing and mobilizing nurses for the internal and external changes needed to actualize their professional roles and responsibilities within any given society.

Particular Issues of Nurses in Chile

The internal and external dimensions of the professional progress of nurses in Chile were discussed in Chapter 8. The oppressive forces that affect nurses exhibit two patterns: One is the universal problem of nurses as women workers, and the second is the sociohistorical development of conflicts with government that are specific to professions in Chile. Both patterns are embedded in the changing class structures in Chile. Nurses in Chile, educated at the university level, are middle-class professionals with gendered connotations (Valdez, 2000). After mandatory affiliation with the nursing association was outlawed in 1981, nurses moved to the current low level of participation in professional organizations and unions. Chilean nurses do not participate in women's activist groups. Women's movements in Chile have exhibited weakened political action in the democratization period of Chilean society since the 1990s. The National Women's Service (SERNAM), as a government agency, has had limited influence in attempts to increase gender equality through public policy avenues (Baldez, 2001). Nurses, as mainly women, still experience high conflict between their gendered roles in the private sphere as housewives and mothers and their professional roles in the health sector (Baldez, 2001; Franceschet, 2003). Professional nurses experience replication of similar patterns in the workplace and in the home that involve double work and little power. Nursing staff experience contradictions between developing their careers and focusing on more personal and private spheres such as marriage and social status. Collectively, nurses feel frustrated and powerless because they perceive that the nursing association emphasizes high political involvement and activism without connection to professional nursing issues at the practice level. Leadership in nursing is seen as a great need in Chile. Upenieks (2003) observed, "Successful nurse leaders are supportive, visionary, knowledgeable, highly visible to clinical nurses, responsive, and tend to preserve power and status within the hospital system" (p. 140). Therefore, a revolution in nurses themselves, their socialization, their culture, and their purpose through individual and collective actions is needed in the pursuit of more autonomy. There is some evidence of the recognition of this need in the

nursing students' questionnaire data, but more attention to dimensions of power and autonomy within nursing would be useful in nursing education programs.

All professions in Chile lack control over professional issues, but in a gendered profession such as nursing, the effects are most devastating. Nurses as women see politics and power from a distance or with apathy, and they are reluctant to engage in struggles to improve their positions. Although a law in the Sanitary Code gave professional nurses legal autonomy in practice and recognition as an independent service with their focus on *care,* it also has implications for nurses in terms of vulnerability to prosecution and legal sanctions. Professional nurses today have an extraordinary opportunity to face the contradictions and solve them. With opportunities for professional development and more collective self-consciousness of the needs of everyone, Chilean nurses could stimulate progress within the nursing community. The challenge for nurses with regard to nursing professional autonomy "evolves from the capacity for advocacy and activism for self to endorsement of advocacy and activism for others" (Boughn, 1995, p. 112). That means that nurses must embrace the struggle for autonomy as part of the empowerment of nurses, as well as a strategy for the improvement of care of patients.

A Model of Empowerment for Women/Nurses in Chile

The participation of nurses in politics and the development of health policies are not compulsory, but are moral or ethical obligations of nurses as citizens and professionals, both individually and collectively (Aroskar, 1993). Mason, Talbott, and Leavit (1993) pointed out that perceiving politics as negative or positive depends on

> some individuals' own biases, experiences, and knowledge of politics; how the game of politics is played; whether the goal or ends are important; and, whether one has a vision for different ways of influencing and is in a position to change the rules of the system. (p. 7)

The last is vital for nurses to address. From a feminist perspective, the politics of power are seen and managed differently between men and women; thus, with patriarchal dominance, "women

have been architects of the reproduction of their own oppression" (Stacey & Price, 1981, p. 10). Empowerment requires "a commitment to connection between self and others, enabling individuals or groups to recognize their own strengths, resources, and abilities to make changes in their personal and public lives" (Mason et al., 1991, p. 7). Empowerment is seen as a process that is helpful to change the distribution of power in a particular cultural context. In Chile there is a need to challenge the patriarchal hierarchical structures, both in the workplace and at home, and to become more democratic and egalitarian.

The feminist 'power-sharing' model (Mason et al., 1991) has three dimensions:

1. *Raising consciousness*: Class, gender, power, and other stratifying structures of society must be included in nursing curricula. Thus nurses can see how health care system structures reflect societal structures. Critical reflection using theoretical insights from hermeneutic phenomenology, critical theory, and feminist theory can also help to discover the matrix of social, health, and gender inequalities. Using reflective practices based on Foucault's views of discourse, nursing students can become more conscious of the forces involved in the development of professional identities. Cotton (2001) explained, "Micro techniques related to reflection and reflective practice include debriefing sessions, reflective journals, logs and diaries, reflective essays, case histories, and clinical supervision" (p. 606). In the case of the marginality of nurses, public perception can shift through the integration of the value of nursing into the identities of nurses and through advocacy as a group in the public sphere.

2. *Positive self-esteem*: Through political participation nurses must gain confidence that they can be self-regulating and control their own lives (Sapiro, 1983). Confidence is a state of self-esteem, but nurses are seen as an oppressed group, probably with a need to improve their self-esteem through their collective identities reflecting pride in the value of their clinical knowledge and practice and their profession. Porter, Porter, and Lower (1989) suggested strategies for increasing nurses' self-esteem such as increasing staff participation in decision making within nursing departments, empowering nurses through courses and workshops, and

developing a system of rewards and recognition in each hospital and faculty. Enhancing the importance of collective group identity fosters appreciation of areas in which personal and private concerns are, in reality, social issues and stimulates participation in political processes. Thus political consciousness can be promoted through increased professional self-esteem, concomitant professional association affiliation, and understanding the need to address injustice through advocacy (Mason et al., 1991).

3. *Political skills*: Skills needed for political action have been suggested for nursing, but most of them are the same as those used in the dominant system. For example, Kingma (1998) thought that nurses have been reluctant to use marketing techniques and suggested the use of marketing in three particularly relevant areas that are new to Chilean nurses: entrepreneur ventures, intrapreneurship ventures, and quality assurance ventures. Creative strategies are needed to compete with institutions from the dominant system. Strong nursing leadership is essential and should be characterized by the generation of democratic leaders and active participation of nurses. Small groups of nurses, working together, can benefit from the energy created through the development of communal ideas, governance over their own work, and control over their own decision-making processes.

The Way Forward: A Model for Empowerment of Care by Nurses in Chile

Empowered caring represents the dialectic between power and care in a greater unity, and it is useful in understanding my research recommendation for more professional autonomy. By using the CARE typology of American Falk Rafael (1996), not only are nurses empowered themselves, but also the nursing that they provide to patients/clients is empowered. The four dimensions of CARE are useful for conceptualizing what could occur in Chile:

1. *Credential*: This pertains to the credibility of nurses as members of the health care system as they undertake their mission of care and understand their legal obligations as professionals. With the Sanitary Code inclusion of an independent role for nurses, nurses in Chile

are well positioned to achieve the clinical autonomy needed to actualize their professional roles. It is incumbent upon them to develop the expertise in clinical practice and nursing education that will demonstrate their value as leaders in health sector policy, practice, and reform.

2. *Association:* Working actively not only with nursing associations, but also with other professional groups such as feminist groups, ecologists, and humanist associations is imperative for nurses to meet their responsibilities as public voices for care as an essential part of human and societal health. Nurses in Chile must become involved with a variety of organizations and expand their influence beyond the health care system or health care team. More nurses and nursing associations need to engage as activists. Participation in activities promoting gender equality may be particularly important in Chile. There is power in unity, a lesson that our medical colleagues learned long ago.

3. *Research*: New dimensions of nursing knowledge centred in more appropriate nursing interventions in healing arts and sciences, alternative health care, primary health care, and education may emerge from engagement in nursing research. Such research could target interventions that make nurses more visible as experts regarding issues of care and could influence nurses' internal and external images in positive ways, in part by demonstrating the value of the current knowledge and skills of nurses and in part by demonstrating the important role that nurses can have in the development of new knowledge related to health issues.

4. *Expertise*: Enhancing nurses' public image and visibility by advocating for more democratic participation in hospitals, where nurses can show their expertise in nursing care, is an imperative. Benner (1984) declared in her book, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, that nursing expertise is a source of power that has a transformative influence on clients' lives. Nurses in Chile are experts in nursing and make important contributions to the care of the sick and the maintenance of the health of the Chilean population. The next step is to demonstrate their expertise through communications targeted at improving their public image. Nurses need to accept opportunities to become active as advocates of caring in

the development, implementation, and evaluation of health services in both the public and the private sectors.

Approaches encompassing both empowerment of nurses and empowerment of care are useful. It is important that the fundamental reason that nursing exists—for the care of the health of the population—is not forgotten or disconnected from the struggle for the empowerment of nurses. Their empowerment must be viewed within the context of improving their ability to actualize their professional responsibilities, or they are unlikely to achieve the autonomy and status that they seek.

Final Reflections: The Importance of Context in the Visualization of the Future of Nursing in Chile

This case study of nurses in Chile is an illustration of how historical, global, and social theoretical contexts intersect in producing the milieus in which social actors, in this case nurses, live and work. Nurses as professionals in Chile, since nursing's origins in the early 1900s, have been influenced by the historical context of the country. Social and political changes, such as the movement from socialist and public service oriented policies to a more capitalist society and greater private sector involvement, have influenced the development of nursing as a profession. Roles have shifted, as has the political environment. Mandatory licensure and compulsory professional association membership have been lost, thus limiting professional autonomy.

From a global perspective, there are clear connections between political and social changes in Chile and the macro level of economic neoliberal policies seen throughout Latin America. Health reform has stimulated changes in roles and responsibilities in nursing practice. In the education of nurses, reform has created new opportunities as private universities have joined public universities in offering nursing programs. The forces of globalization may increase the mobility of Chilean nurses, who may have more opportunities to work and study abroad. Space has opened for nurses to achieve greater clinical autonomy through legislation that

supports independent nursing practice. It seems strange that political and policy changes in Chile have both constrained professional monopolies and thus autonomy in terms of control over the nursing profession, and simultaneously created opportunities for greater clinical autonomy.

Social theory, particularly postmodernism and feminist theory, seem to be useful explanations for what is occurring. With multiple narratives, there are multiple possibilities. What encourages changes also constrains. Power circulates, waxes and wanes. Gender relations and nursing as a gendered profession are intertwined, making the actualization of nursing as a profession challenging and frustrating. There are opportunities for nurses and nursing to gain power and status, but there is no unity within the discipline. Strong leadership is needed. As has been stated, success is most likely if the empowerment of nursing is connected, both within individual nurses and within societal consciousness, to the empowerment of care. With social recognition of the value of nurses' work will emerge social recognition of the value of the profession of nursing.

The literature suggested that the struggles of nurses and nursing match similar struggles for nursing autonomy worldwide. Chilean nurses need determination, courage, and perseverance, both individually and collectively. They need champions, from both within and outside nursing. Most important, they need to understand that barriers can also create opportunities, that power can be won and lost, and that times of social transformation open social spaces for social actors who are ready to lead. Will nurses and nursing be ready when the next opportunities emerge?

Understanding the historical, social, and professional contexts in which nursing is located in Chile can illuminate the way forward.

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APPENDIX A:

RECRUITMENT DOCUMENTS

Appendix A: Recruitment Documents

Recruitment Letter to Hospital Administrators

Part 1: Identification

Project title: Professional nursing in Chile.

Researcher: Ms. Eugenia Urra, RN, Ph. D. Student / Contact person: Ms. Ana Maria Vasquez
Affiliation: Department of Nursing, University of La Serena, Phone: 56-51-204300
Department of Nursing, University of La Serena, Phone: 56-51-204003

Co-Supervisor(s):
Linda Ogilvie, Ph. D; Pauline Paul, Ph. D.
Associate Professors, Faculty of Nursing, University of Alberta.
linda.ogilvie@ualberta.ca / pauline.paul@ualberta.ca

Part II. Information about the purpose of the research

I am a Ph.D. nursing student in the Faculty of Nursing at the University of Alberta, Edmonton, Canada. I am doing my research and would like to ask to permission to ask nurses who work in your institution to participate in this research project. For this study, I need a group of Chilean professional nurses who have worked for at least for 2 years in the same hospital, one of the higher positions, one head nurse and five staff nurses. The purpose of the study is to learn about professional nursing in Chile. I want to know about professional practice in both public and private hospitals, covering aspects of professional issues of relevance, such as perceptions, responsibilities, and identities in nursing practice.
It is not expected that there will be any risk in taking part in the study. The researcher is interested in using the information to analyze professional nursing practice in order to contribute to our knowledge of professional nursing in Chile. Nurses who consent to participate will be free to refuse to answer any questions and will be free to withdraw from the study at any time.
Please find attached a copy of the consent form that will be used with your staff.

"I agree that Eugenia Urra can approach nursing staff at _____
to request volunteers to participate in the study professional nurses in Chile"

_____ _____

Sign Date

Recruitment Letter to Director of Nursing Programs

Part 1: Identification

Project title: Professional nursing in Chile.

Researcher: Ms. Eugenia Urra, RN, Ph. D. Student / Contact person: Ms. Ana Maria Vasquez
Affiliation: Department of Nursing Department of Nursing
University of La Serena University of La Serena
Phone: 56-51-204300 Phone :56-51-204003
Co-Supervisor(s):
Linda Ogilvie, Ph. D; Pauline Paul, Ph. D.
Associate Professors, Faculty of Nursing, University of Alberta.
linda.ogilvie@ualberta.ca /pauline.paul@ualberta.ca

Part II. Information about the purpose of the Research.

I am a Ph.D. nursing student in the Faculty of Nursing at the University of Alberta, Edmonton, Canada. I am doing my research and would like to ask to permission to ask students and faculty in your institution to participate in this research project. For this study, I need a group of Chilean nursing faculty and nursing students to respond to questionnaires. The purpose of the study is to learn about professional nursing in Chile. I want to know about professional nursing education, covering aspects of professional issues of relevance, such as perceptions, responsibilities, and identities in nursing practice.
It is not expected that there will be any risk in taking part in the study. The researcher is interested in using the information to analyze professional nursing practice in order to contribute to our knowledge of professional nursing in Chile. Faculty members and students who consent to participate will be free to refuse to answer any questions and will be free to withdraw from the study at any time. Consent to participate in the study will be implied by return of completed questionnaires. Please find attached a copy of each of the questionnaires that will be used for this study.

"I agree that Eugenia Urra can approach students and faculty at_____
to request volunteers to participate in the study professional nurses in Chile."

_____ _____

Sign **Date**

APPENDIX B:

INVITATIONS, INFORMATION SHEETS, AND CONSENT FORMS

Appendix B: Invitations, Information Sheets, And Consents

Invitation to Staff Nurses

STAFF NURSES NEEDED

My name is Eugenia Urra and I am a Ph.D. nursing student at the University of Alberta, in Edmonton, Canada. I am doing my research project for my dissertation and would like to interview some staff nurses.

The purpose of the study is to learn about professional nursing practice in both public and private hospitals, covering aspects of professional issues of relevance, such as perceptions, responsibilities, and identities in nursing practice.

I am looking for 5 professional nurses who have worked for at least 2 years in this hospital. Participation in this project is voluntary.

If you agree to participate in this study, I will interview you for approximately one hour. The interview will be tape-recorded so that it may be transcribed accurately. The interview will take place at a time and location of your choice. Your identity will not be revealed and I will not use your name in any publications.

If you think that you may be interested in participating in this study and would like more information, please contact me at (phone number).

Invitation to Head Nurses

HEAD NURSE NEEDED

My name is Eugenia Urra and I am a Ph.D. nursing student at the University of Alberta, in Edmonton, Canada. I am doing my research project for my dissertation and would like to interview some nurses.

The purpose of the study is to learn about professional nursing practice in both public and private hospitals, covering aspects of professional issues of relevance, such as perceptions, responsibilities, and identities in nursing practice.

I am looking for one head nurse who has worked for at least 2 years in this hospital. Participation in this project is voluntary.

If you agree to participate in this study, I will interview you for approximately one hour. The interview will be tape-recorded so that it may be transcribed accurately. The interview will take place at a time and location of your choice. Your identity will not be revealed and I will not use your name in any publications.

If you think that you may be interested in participating in this study and would like more information, please contact me at (phone number).

Information Letter for Nurses Employed in Hospitals

Part 1: Identification

Project title: Professional nursing in Chile.

Researcher: Ms. Eugenia Urra, RN, Ph. D. Student / Contact person: Ms. Ana Maria Vasquez
Affiliation: Department of Nursing Department of Nursing
University of La Serena University of La Serena
Phone: 56-51-204300 Phone: 56-51-204003

Supervisor(s):
Linda Ogilvie, Ph.D.; Pauline Paul, Ph.D.
Associate Professors, Faculty of Nursing, University of Alberta.
linda.ogilvie@ualberta.ca / pauline.paul@ualberta.ca

Part 2: Information for Head Nurses

I am a Ph.D. in nursing student in the Faculty of Nursing at the University of Alberta, Edmonton, Canada. I would like to ask you to participate in a research project, by inviting you to be interviewed for approximately one hour. The Ethics Research Board of the University of Alberta has approved this project.

The purpose of the study is to learn about professional nursing practice in both public and private hospitals, covering aspects of professional issues of relevance, such as perceptions, responsibilities, and identities in nursing practice.

There are no direct benefits for you for participating in this study. There are also no known risks to you for participating in this study. Participation in this project is voluntary. If you agree to participate in this study, I will interview you for approximately one hour. The interview will be tape-recorded so that its content may be transcribed accurately. The interview will take place at a time and location of your choice. You have the right to refuse to answer any questions and you also have the right to withdraw your consent to participate at any time during the interview. I will not inform your employer about your participation or non-participation in this study.

All taped interviews will be transcribed by myself. Your name will not be used in this transcription. Instead I will use a fictional name. Beside myself, the only people who will have access to the transcript of your interview will be the members of my supervisory committee in Canada, and possibly a translator.

Your identity will not be revealed and your name will not be used in any publications. If I use direct citations from your interview all efforts will be taken to ensure that your identity cannot be revealed.

The Ethics Board of the University of Alberta requires that all original data will be kept in a secure location for a period of five years.

If you have any questions about this study do not hesitate to contact me at: Phone number.

If you have any concerns about this study do not hesitate to contact Ms Ana Maria Vasquez at 56-51-204003.

Initial :_____

Information Letter for Professional Nurses Representatives

Part 1: Identification

Project title: Professional nursing in Chile.

Researcher: Ms. Eugenia Urra, RN, Ph. D. Student / Contact person: Ms. Ana Maria Vasquez
Affiliation: Department of Nursing Department of Nursing
University of La Serena University of La Serena
Phone: 56-51-204300 Phone :56-51-204003

Supervisor(s)
Linda Ogilvie, Ph. D; Pauline Paul, Ph.D.
Associate Professor, Faculty of Nursing, University of Alberta.
linda.ogilvie@ualberta.ca / pauline.paul@ualberta.ca

Part II: Purpose of the research

I am a Ph.D. in nursing student in the Faculty of Nursing at the University of Alberta, Edmonton, Canada. I would like to ask you to participate in a research project, by inviting you to be interviewed for approximately one hour. The Ethics Research Board of the University of Alberta has approved this project.
The purpose of the study is to learn about professional nursing practice in both public and private hospitals, covering aspects of professional issues of relevance, such as perceptions, responsibilities, and identities in nursing practice.

There are no direct benefits for you for participating in this study. There are no known risks to you for participating in this study. Participation in this project is voluntary. If you agree to participate in this study, I will interview you for approximately one hour. The interview will be tape-recorded so that its content may be transcribed accurately. The interview will take place at a time and location of your choice. You have the right to refuse to answer any questions and you also have the right to withdraw your consent to participate at any time during the interview.

All taped interviews will be transcribed by myself. Beside myself, the only people who will have access to the transcript of your interview will be the members of my supervisory committee in Canada, and possibly a translator. What you tell me may be directly quoted in my dissertation and in publications and presentations who you are will be disguised unless you give me permission to identify you.
The Ethics Board of the University of Alberta requires that all original data will be kept in a secure location for a period of five years

If you have any questions about this study do not hesitate to contact me at: Phone number.
If you have any concerns about this study do not hesitate to contact Ms Ana Maria Vasquez at 56-51-204003.

Initial: _____

Consent Form for Interview of Nurses Employed in Hospitals

Part 1: Researcher information

Project title: Professional nursing in Chile.

Researcher: Ms. Eugenia Urra, RN, Ph. D. Student / Contact person: Ms. Ana Maria Vasquez
Affiliation: Department of Nursing Department of Nursing
University of La Serena University of La Serena
Phone: 56-51-204300 Phone :56-51-204003
Co-Supervisor(s):
Linda Ogilvie, Ph. D; Pauline Paul, Ph. D.
Associate Professors, Faculty of Nursing, University of Alberta.
linda.ogilvie@ualberta.ca / pauline.paul@ualberta.ca

Part 2. Consent of subjects

	Yes	No
Do you understand that you have been asked to be in a research study?	___	___
Have you read and received a copy of the attached information sheet?	___	___
Do you understand the benefits and risks involved in taking part? in this research study?	___	___
Have you had an opportunity to ask questions and discuss the study?	___	___
Do you understand that you are free to refuse to participate or withdraw from the study at anytime? You understand that it will not affect your employment?	___	___
Have the issues of confidentiality been explained to you? Do you understand who will have access to the data collected in this study?	____	___

Part 3: Signatures

This study was explained to me by: _____
Date: _____

I agree to take part in this study

Signature of research participant: _____
Printed name: _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of researcher:_____
Printed name: _____

Consent Form for Interview of Professional Nurse Representatives

Part 1: Researcher information

Project title: Professional nursing in Chile.

Researcher: Ms. Eugenia Urra, RN, Ph. D. Student / Contact person: Ms. Ana Maria Vasquez
Affiliation: Department of Nursing Department of Nursing
University of La Serena University of La Serena
Phone: 56-51-204300 Phone :56-51-204003
Co-Supervisor(s):
Linda Ogilvie, Ph. D; Pauline Paul, Ph. D.
Associate Professors, Faculty of Nursing, University of Alberta.
linda.ogilvie@ualberta.ca / pauline.paul@ualberta.ca

Part 2: Consent of subjects

	Yes	No
Do you understand that you have been asked to be in a research study?	___	___
Have you read and received a copy of the attached information sheet?	___	___
Do you understand the benefits and risks involved in taking part? in this research study?	___	___
Have you had an opportunity to ask questions and discuss the study?	___	___
Do you understand that you are free to refuse to participate or withdraw from the study at anytime?	___	___
Have the issues of confidentiality been explained to you? Do you understand who will have access to the data collected in this study?	___	___

Part 3: Signatures

This study was explained to me by: _____
Date: _____

I agree to take part in this study

Signature of research participant: _____
Printed name: _____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

Signature of researcher:_____
Printed name: _____

APPENDIX C:

DATA COLLECTION TOOLS

Appendix C: Data Collection Tools

Interview Participant Profile

Participant # _____

1. When did you complete your undergraduate nursing program? 19_____

2. For how many years have you worked as a nurse? _____years

3. What kinds of work have you done as a nurse?

_____;_____;_____

4. Where did you do your undergraduate nursing preparation?

_____

5. Do you have any graduate preparation? YES ____NO___

If yes, what is it? _____

Interview Guide for Staff Nurses

1. Tell me, what made you choose this job?
   - How did you find it?
   - What other places did you consider working?
   - What is the best thing about this job?
   - What is the worst thing about this job?

2. Can you explain your routine for one day at work?
   - What do you do?
   - What decisions do you make?
   - How do you use your nursing knowledge and skills in the work that you do? To what extent?
   - Are you able to give good nursing care in the place that you work? Please explain the reason for your answer?
   - What changes would make it easier for you to give good nursing care?

3. You are considered a professional nurse in Chile. What does being a professional mean to you?
   - How satisfied are you with the position of nursing in Chilean society?
   - What would you like to see change?
   - How could these changes be achieved?
   - Are you registered with the Chilean Association of Nursing Education? Why? (Or why not)
   - What is the purpose of Chilean Nursing Association? Is it succeeding?
   - What would you like to see in CHNA do?
   - Are you a member of any other professional association? (if yes, why do you belong?)

4. What things about Chilean society make it difficult for you to achieve your professional goals?

5. Do you have anything else that you wish to share with me?

Interview Guide for Head Nurses

1. Tell me, what made you choose this job?

   How did you find it?
   What other places did you consider working?
   What is the best thing about this job?
   What is the worst thing about this job?

2. Can you explain your routine for one day at work?

   What do you do?
   What decisions do you make?
   How do you use your nursing knowledge and skills in the work that you do? To what extent?
   Are the nurses in your unit able to give good nursing care? Please explain the reason for your answer.
   What changes would make it easier for nurses in your unit to give good nursing care?

3. You are considered a professional nurse in Chile. What does being a professional mean to you?

   How satisfied are you with the position of nursing in Chilean society?
   What would you like to see change?
   How could these changes be achieved?
   Are you registered with the Chilean Association of Nursing Education? Why? (Or why not)
   What is the purpose of Chilean Nursing Association? Is it succeeding?
   What would you like to see in CHNA do?
   Are you a member of any other professional association? (if yes, why do you belong?)

4. What things about Chilean society make it difficult for you to achieve your professional goals?

5. Do you have anything else that you wish to share with me?

Interview Guide for Highest Ranking Nurse in the Hospital

1. How do you recruit professional nursing staff?

   How difficult is it to find qualified nurses? Why?
   From what educational institutions do you recruit nurses? (Are there some preferences?)
   This is a – private/public hospital – do most of your nursing staff come from private/public educational institutions? If yes, why do you think this happens?
   How much power do you have with respect to hiring, evaluation, and disciplining of professional nurses in your hospital?
   How satisfied are you with your level of participation? Why?
   Are there changes that you would like to make?

2. How would you describe the working conditions for nurses in this hospital?

   When professional nurses are hired, how long do they usually stay in their jobs at this hospital?
   How satisfied are you with the quality of nursing care?
   What supports do you have for ensuring that nurses have what they need to provide good nursing care?
   What would make things better?

3. You are considered a professional nurse in Chile. What does being a professional mean to you?

   How satisfied are you with the position of nursing in Chilean society?
   What would you like to see change?
   How could these changes be achieved?
   Are you registered with the Chilean Association of Nursing Education? Why? (Or why not)
   What is the purpose of Chilean Nursing Association? Is it succeeding?
   What would you like to see in CHNA do?
   Are you a member of any other professional association? (if yes, why do you belong?)

4. What things about Chilean society make it difficult for you to achieve your professional goals?

5. Do you have anything else that you wish to share with me?

Interview Guide for Representative of Chilean Association of Nursing Education (CHNEA)

1. What is the role of the Chilean Association of Nursing Education?

2. How much influence does the CHNEA have on the development of nursing education in Chile?
   On curriculum?
   On standards of education?
   On development of new undergraduate and graduate programs?
   What percentage of nurse educators are members?
   Is your relationships different in private as opposed to public university schools of nursing?

3. To what extent is nursing in Chile a profession?

4. What criteria for a profession are you using?

   How well does nursing in Chile fit with these criteria?

5. What changes are needed in nursing education to:

   Improve nursing practice?
   How can these changes be achieved?
   Improve the professional status of nurses?

6. What are the societal barriers to making such changes?

7. Are you a member of CHNA?

   Why do you choose or not choose to be a member?

8. Do you have anything else that you wish to share with me?

Interview Guide for Representative of the Chilean Nursing Association (CHNA)

1. What is the role of CHNA?
   - What activities is it currently involved in?
   - Which of these is most important? Why?
   - How important is legislation to defining nursing practice?
   - How important is mandatory registration /licensure for nurses?
   - What does CHNA hope to achieve in the next year, next five years, and next ten years?
   - What barriers are you likely to encounter?

2. What percentage of nurses in Chile belong to CHNA?
   - What are the advantages of belonging?
   - Why might nurses choose not to belong?
   - Are there any plans to increase memberships? If yes, what strategies are likely to be implemented?

3. Does CHNA have ties with nursing associations in other countries? If yes, what is the significance of such ties?

4. What role does CHNA have with respect to nursing education?

5. What are the greatest challenges facing nurses in Chile today?
   - How is CHNA responding to these challenges?
   - Are there features of Chilean Society that enhance or impede the effectiveness of CHNA initiatives?

6. Is nursing a profession in Chile?
   - What criteria for a profession are you using?
   - What needs do to be done to enhance the professional status of nurses?

7. Do you have anything else that you wish to share with me?

Interview Guide for Representative of the Ministry of Health (MOH)

1. What is your role in the Ministry of Health?

   What do you do?
   How do you relate with other ministry personnel?
   How do you relate with the government?
   What influence do you have regarding the development of health policy?

2. How many other nurses work in the ministry?

   What are their roles?
   How does a nurse get a job in the ministry?
   What are the educational qualifications of nurses in the ministry?

3. How would you describe the working conditions of nurses in Chile?

   Are there differences in the private and public health sector?
   What is happening at the ministry level to improve the working conditions of nurses?
   How do working conditions of nurses in Chile relate to standards of patient care?

4. What do you think are the major challenges facing nursing in Chile today?

   What needs to happen for things to change?
   How difficult will such changes be in Chilean society?

5. Do you consider nursing, as practiced in Chile today, a profession?

   What criteria for profession are you using?
   Please, give the reasons for your answer.

6. How can legislation enhance the professionalization of nursing?

   How much influence do nurses in the ministry of health have with regard to legislative or policy changes affecting nurses?
   Are you a member of CHNA?

7. Do you have anything else that you wish to share with me?

Questionnaire for Faculty Member Nurses in Public and Private Institutions

Date:_____

Number Institution: 000000

Part 1: Identification

Project title: Professional nursing in Chile.

Researcher: Ms. Eugenia Urra, RN, Ph. D. Student / Contact person: Ms. Ana Maria Vasquez
Affiliation: Department of Nursing, University of La Serena, Phone: 56-51-204300
Department of Nursing, University of La Serena, Phone: 56-51-204003

Co-Supervisor(s):
Linda Ogilvie, Ph. D.; Pauline Paul, Ph. D.
Associate Professors, Faculty of Nursing, University of Alberta.

Part II: Purpose of the research.

I am a Ph.D. in nursing student in the Faculty of Nursing at the University of Alberta, Edmonton, Canada. I would like to ask you to participate in a research project, by inviting you to respond to the attached questionnaire. The Health Ethics Research Board of the University of Alberta has approved this project.
The purpose of the study is to learn about professional nursing in Chile. I want to know about professional nursing practice, covering aspects of professional issues of relevance, such as perceptions, responsibilities, and identities in nursing practice.
There are no direct benefits for you for participating in this study. However, responding to this questionnaire should contribute to knowledge about professional nursing in Chile. It should not take more than 30 minutes of your time.
There are no known risks to you for participating in the study. Your name and the name of your school will not appear in any presentations or publications. Responses to this questionnaire will be presented in the form of an aggregate. The Ethics Board of my University requires that all original data will kept in a secure location for a period of five years.
You have the right to refuse to participate in this study. This can be done by not returning the attached questionnaire. Your participation is entirely voluntary. You have the right to refuse to answer any questions. Your consent to participate in this study is implied by returning the completed questionnaire in the attached envelope.

Thank you for your collaboration.

Part A

1. What year did you graduate from nursing? _____
2. What is your highest educational qualification?
   In nursing:_____ (year_____)
   In another discipline:_____(year_____)

3. For how many years did you practice as a clinical nurse?_____

4. For how many years have you taught nursing or been involved in nursing education?_____

What nursing subjects have you taught?

_____

6. Are you a member of CHNA? Yes ___ No____

7. Are you a member of the Chilean Association of Nursing Education? Yes __ No___

Part B

1. Do you think that nursing is a profession in Chile? Yes ____ No___

2. Please give your reasons for the answer you gave in question 1

_____
_____
_____

3. In your opinion, what changes are needed to increase the professional status of nurses in Chile?

_____

4. In your opinion, what strategies are needed to implement the changes that you suggested?

_____
_____
_____
_____

5. Is there anything else that you would like to add?

_____

Thank you.

Questionnaire for Nursing Students in the Public and Private Institutions

Date :_____

Identification Number: 000000000

Part 1: Identification

Project title: Professional nursing in Chile.

Researcher: Ms. Eugenia Urra, RN, Ph. D. Student / Contact person: Ms. Ana Maria Vasquez
Affiliation: Department of Nursing Department of Nursing
University of La Serena University of La Serena
Phone: 56-51-204300 Phone: 56-51-204003

Co-Supervisor(s):
Linda Ogilvie, Ph. D; Pauline Paul, Ph. D.
Associate Professors, Faculty of Nursing, University of Alberta.

Part II. Purpose of the research

I am a Ph. D in nursing student in the Faculty of Nursing at the University of Alberta, Edmonton, Canada. I would like to ask you to participate in a research project, by inviting you to respond to the attached questionnaire. The Health Ethics Research Board of the University of Alberta has approved this project
The purpose of the study is to learn about professional nursing in Chile. I want to know about professional nursing practice, covering aspects of professional issues of relevance, such as perceptions, responsibilities, and identities in nursing practice.
There are no direct benefits for you for participating in this study. However, responding to this questionnaire should contribute to knowledge about professional nursing in Chile. It should not take more than 45 minutes of your time.
There are no known risks to you for participating in the study. Your instructors will not know if you participate or do not participate in this project. Participating, or not participating, will not affect your academic standing. Your name and the name of your school will not appear in any presentations or publications. Responses to this questionnaire will be presented in the form of an aggregate. The Ethics Research Board of the University of Alberta requires that all original data will kept in a secure location for a period of five years.
You have the right to refuse to participate in this study. This can be done by not returning the attached questionnaire.
Your participation is entirely voluntary. You have the right to refuse to answer any questions.
Your consent to participate in this study is implied by returning the completed questionnaire in the attached envelope.

Thank for your collaboration.

Part A

1. What is your age? _____

2. Why did you choose nursing as a program?

Are you happy with your choice of nursing as a program? Yes ___ No____

Please, explain the reason for your answer to question number 3.

What kind of position do you hope to have in nursing in the future?

Are you a member of your nursing student association? Yes__ No___

Give the reason why you choose or not choose to be a member of the association?

Part B

1. Do you think nursing is a profession in Chile? Yes __ No___

2. On what basis did you give your answer to question number 1?

3. How would you define a profession?

4. What criteria are needed for an occupation to be a profession?

5. What needs to change to increase the professional status of nurses in Chile?

6. What strategies are needed to implement the changes that you suggested?

7. Is there anything else that you would like to add?

Thank you.

APPENDIX D:

ETHICAL APPROVAL

Health Research Ethics Board | biomedical research | health research

2J2.27 Walter Mackenzie Centre
University of Alberta, Edmonton, Alberta T6G 2B7
p.780.492.9724 f.780.492.7883
ethics@mesl.ualberta.ca

3-48 Corbett Hall, University of Alberta
Edmonton, Alberta T6G 2G4
p.780.492.0839 f.780.492.1626
ethic@www.rehabmed.ualberta.ca

UNIVERSITY OF ALBERTA HEALTH SCIENCES FACULTIES,
CAPITAL HEALTH AUTHORITY, AND CARITAS HEALTH GROUP

HEALTH RESEARCH ETHICS APPROVAL

Date:	January 2002
Name of Applicant:	Ms. Eugenia Urra
Organization:	University of Alberta
Department:	Graduate Studies; Nursing
Name of Supervisors:	Dr. Linda Ogilvie & Dr. Pauline Paul
Organization:	University of Alberta
Department:	Nursing
Project Title:	Professional Nursing in Chile

The Health Research Ethics Board (HREB) has reviewed the protocol for this project and found it to be acceptable within the limitations of human experimentation. The HREB has also reviewed and approved the subject information material and consent form (if applicable).

The deliberations of the HREB included all elements described in Section 50 of the *Health Information Act*, and found the study to be in compliance with all the applicable requirements of the Act.

The approval for the study as presented is valid for one year. It may be extended following completion of the yearly report form. Any proposed changes to the study must be submitted to the Health Research Ethics Board for approval. Written notification must be sent to the HREB when the project is complete or terminated.

Dr. Sharon Warren
Chair of the Health Research Ethics Board (B: Health Research)

File number: B-071201-NSG

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